

Data integration on inflammatory bowel disease

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Preface



UNIVERSITAT DE
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ciber iSciⁱⁱ

The main topic of the thesis is [data integration](#) applied in the [inflammatory bowel disease \(IBD\)](#) research. This disease is complex, for instance it is not known if the cause behind Crohn's disease and ulcerative colitis is the same. There are hypothesis pointing that the [microbiome](#) is a major factor in the disease, which together with an aberrant immune response is the dominant theory. In order to find robust relationships between the microbiome and the immune system it is important to consider all the relevant variables that influence a disease. On this thesis I seek these relationships using data from different sequencing technologies and the observed or reported phenotype of the patients.

The thesis was carried out on the [Institut d'Investigacions Biomèdiques August Pi i Sunyer \(IDIBAPS\)](#) research institute and funded by [Centro de Investigación Biomédica en Red \(CIBER\)](#). The thesis was done on the [IBD unit](#) which is a translational team of biologist, microbiologists, veterinaries, bioinformaticians, doctors and nurses (at [Hospital Clínic](#)) in a multidisciplinary team. The leading doctor of the unit was [Julian Panés](#) whose interest on the disease lead to receiving a grant that made possible this thesis.

The thesis is on the [doctoral programme in biomedicine](#) of the [University of Barcelona \(UB\)](#). My thesis directors' were [Juanjo Lozano](#) and [Azucena Salas](#), my boss, who helped as bioinformatician and disease expert respectively. They provided advice and guidance on how to analyse the data and where to focus on the different experiments/analysis.

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Abstracts

English

Introduction: Inflammatory bowel disease is a complex disease with several factors that affect each other. The origin and process that maintains the disease is not fully understood, and current treatments focus on early detection of the disease and prevent the accumulation of damage on the intestine. Finding those relationships will help to advance treatments, diagnosis or prevent it.

Methods: To identify these relationships we based our analysis on intestinal bacterial 16S data and human transcriptome from biopsies. We used canonical correlation analysis to find models that are coherent with previous knowledge on the biology of the disease and provide insights on the relationships between bacteria and genes.

Results: We compared our own methods with previously published methods, mainly MCIA, to assess the advantages and disadvantages of the different proposed relationships. Furthermore, the classification of samples was used to find which methods provide are more accurate.

Discussion: Biological relevance, difficult.

Conclusion: Chips or further tests.

Spanish

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Discussió: Biological relevance, difficult.

Conclusió: Chips or further tests.

Catalan

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Discussió: Biological relevance, difficult.

Conclusió: Chips or further tests.

Chapter 1

Introduction

Inflammatory bowel disease (IBD) involves Crohn's disease (CD) and ulcerative colitis (UC). It generally affects the terminal ileum and the colon but it can involve any segment of the gastrointestinal tract. UC is a recurrent, chronic and continuous inflammation of the colon and rectum while the CD is not a continuous inflammation and affects the whole gastrointestinal tract causing transmural inflammation.

IBD etiology is unknown. However, once it has initiated the most prevalent hypothesis of its chronicity suggests an aberrant immunological response to antigens of the commensal microbiome.

To diagnose IBD doctors use endoscopy and/or magnetic resonance imaging and histologies.

Treatments provided for IBD include, noninflammatory drugs, suppressors and biologics, i.e, anti TNF- anti-IL2, 23, anti-integrin $\alpha 4\beta 7$. The therapeutic options can induce remission in some patients, but they often need continuous treatment to avoid recurrence. Nevertheless, many patients are refractory or intolerant to those therapies and need to undergo surgery or other strategies like dietetic and psychological support [1] .

1.1 Inflammatory bowel disease

IBD includes the CD and UC which are characterized by alternating periods of remission and clinical relapse that mainly affect the gastrointestinal tract. CD is a progressive relapsing disease that can affect all the gastrointestinal tract but shows mostly on both terminal ileum and colon with a discontinuous inflammation. UC is a colonic relapsing disease characterized by continuous inflammation of the colon. Both of them have different risk factors, clinical, endoscopic and histological characteristics (see sections 1.1.2 and 1.1.3).

Around 3.5 million individuals have IBD in Europe and North America combined [2]. IBD is more commonly found in industrialized and developed regions, suggesting that environmental factors might greatly influence IBD occurrence.

In addition, the incidence of IBD is increasing in areas, such as Asia or Eastern Europe, where the number of cases was relatively low hitherto [3].

The dysregulation of the inflammatory response observed in IBD requires interplay between host genetic factors and the intestinal microbiome. Several studies support the concept that IBD arise from an exacerbate immune response against commensal gut microorganisms. Nonetheless, the disease could result from an imbalanced microbial composition leading to generalized or localized dysbiosis¹.

The role of the gut microbiome in IBD is an active ongoing field of research. Several authors are currently studying the alterations reported in IBD of the intestinal microbiome. However, it is still unclear the cause-effect relation between dysbiosis and IBD. Partly due to the multiple variables already identified that have been linked to IBD; for instance, age, diet, usage of antibiotic, tobacco, and socioeconomic status [4].

The relationship between host and microbiome has been proposed to play a fundamental role in maintaining disease. For instance, some *Proteobacteria* species which have adherent and invasive properties might exploit host defenses and promote a proinflammatory environment, altering the intestinal microbiota in favor of dysbiosis [5].

The epithelium is often damaged and might present ulcers or other inflammation symptoms. A segment of the gastrointestinal tract might recover if the patient receives treatment or due the natural cycles of the disease. But once a segment is affected by the disease it can be considered as involved, as some damage remains even if the tissues is no longer inflamed.

1.1.1 Etiology and pathogenesis

Several mechanisms have been proposed to drive IBD pathogenesis [6, 7]. Some of them are based on a relationship between the immune system and the microbiome [8, 9]. It is also unclear if CD and the UC share the same origin considering their different symptoms.

There is also evidence of some genetic component on the onset of the disease, specially if the disease appears very early (less than 2 years old patients) [10, 11]. Disease can be classified based on age at onset as very early, early or adult on-set disease [11]. Genome-wide association studies (GWAS) have linked IBD to over 100 genetic loci, including a *NOD2* gene, but so far there is not any known mechanism how polymorphism on this genes are driving the disease [12]. On early pediatric and adult disease the genetic component is lower than on very early on set and it is thought that the environmental factors are the main cause of the disease at those ages.

On the following sections I will explore the role of several of the possible factors involved on the pahtogenesis, starting with the genetics.

¹A signature is usually a group of features that describe/are representative of a cell line or a process or a stage.

1.1.1.1 Genetics

IBD is not an heritable disease, except for very early onset IBD, but it has some genetic influence that predisposes people to have it.

This has lead to look for genetic factors on IBD both on general population and on the early cases. Genome wide association studies (GWAS) are one of the most common genetic studies performed, together with methylation studies. To discover through linkage disequilibrium genetic variations linked to phenotypes and regulatory transcription changes, respectively.

With GWAS several alleles on protein coding loci have been found, rising to around 300 genetic variants [13]. Particularly, the *NOD2* gene is highly relevant for the disease on European patients, as it is a risk alleles for CD loci but show significant protective effects in UC [14, 15]. The mechanism of how this gene protects from UC has not been confirmed yet [12].

Many of the relevant genetic loci related to IBD are not on protein coding fragments of the genome. Recently expression quantitative trait loci (eQTL) particularly showed [10] that locis are on enhancers or promoters like e.g. H3K27Ac or promoter e.g. H3K4me1 marks as found by chromatin immunoprecipitation sequencing ([CHIP-Seq](#)).

1.1.1.2 Microbiome

The human intestine is a large reservoir of co-existing microorganisms (bacteria, fungi, viruses, and unicellular eukaryotes). This microbiome community exerts different functions in the human body influencing nutrients' metabolism, the maturation of the immune system while suppressing the growth of harmful microorganisms' [16].

The role of the gut microbiota has been proposed to play a role in IBD pathogenesis. IBD has been characterized by a breakdown in the balance between beneficial and harmful bacteria that are present in the human gut compared to healthy individuals [17, 18].

Indeed, many studies show that patients with IBD have less biodiversity. Biodiversity is measured on α (alfa) and β (beta) diversity. α -diversity is a measure of the species present on a single sample and its abundance while β -diversity compares the diversity between samples. There are some reports of taxonomic changes and increase on *Enterobacteriaceae* sp, *Escherichia coli* (specially the invasive strain) at the mucosal layer of IBD patients [19]. At the same time there is often a reduction of protective species like *Bifidobacterium*, *Lactobacillus* and *Faecalibacterium* which might be able to protect individuals from mucosal inflammation via several mechanism such as a downregulation of proinflammatory cytokines or the stimulation of IL-10 and antiinflammatory cytokines [19]. Specially *Faecalibacterium prausnitzii* is one microorganism of interest [20, 21].

In fact, it has been recently proposed that several unique microbial species can distinguish healthy controls from UC and CD patients [22, 23].

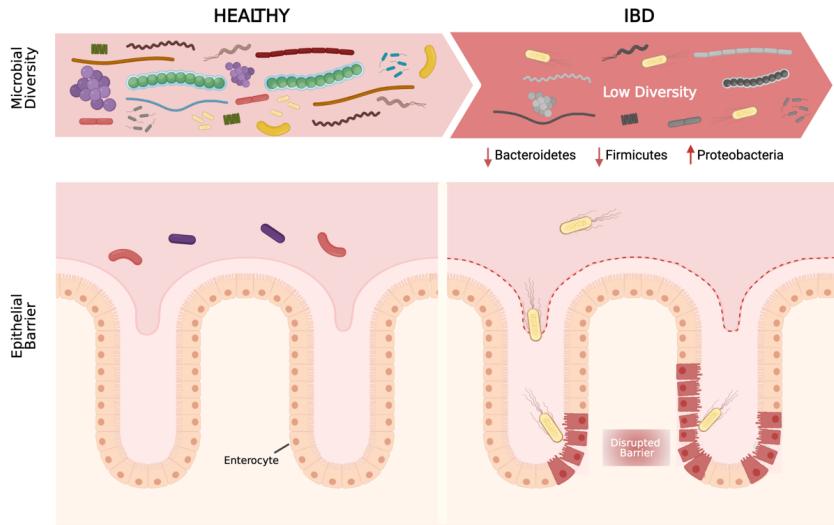


Figure 1.1: The microbial composition in a healthy and IBD gut.

One of the proposed mechanism of crosstalk between bacteria and host is through bacterial metabolites. They interact with the cells and modulate the state of the intestine. One example of such metabolite is butyrate which has been linked to microorganisms presents on healthy intestines and shown to interact with intestine cells and help regulate some genes [24].

As previously mentioned, adherent invasive *Escherichia coli*, a proteobacteria specie, has been associated with IBD [25]. Adherent invasive strains are mainly found in ileal and colonic samples of CD patients and their presence in UC is less clear. These adherent invasive cells enter through the epithelium of the more permeable cells and live on their cytosol.

The metabolic cocktail composed of soluble factors secreted by life probiotic bacteria, living microorganisms which, when administered in adequate amounts, confer health benefits on the host [26–30] or any bacterial-released molecule capable of providing health benefits through a direct or indirect mechanism, has been collectively known as postbiotics since 2012 [26].

1.1.1.3 Immune response

As explained previously the immune system plays a role in IBD pathogenesis and pathophysiology.

Loss of tolerance to commensal bacteria has been suggested as the underlying mechanism triggering the inflammation on the intestine. The immune response

involves many different cell lines and regions, which are important to know how they organize for a better understanding of the disease.

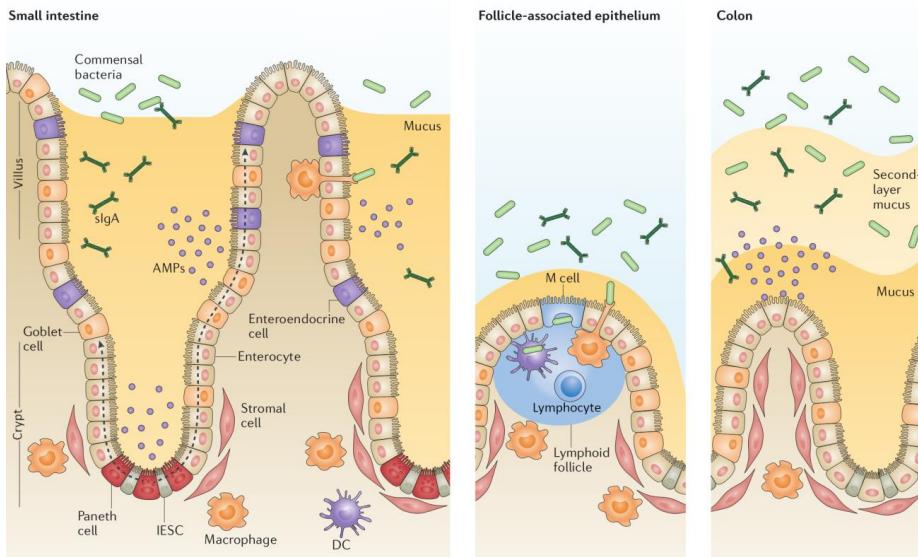


Figure 1.2: The intestinal epithelial barrier.

From the luminal side of the intestine, the first layer is the mucosa (See sections 1.2 or 1.1). In the colon the mucus is organized in two layers: the inner layer, a firm mucus layer; and the outer, loose mucus layer [31]. The intestinal epithelium is a single layer of cells organized into crypts and villi (and circular folds on the large intestine) that carries out a diverse array of functions besides digestion performed by specialized cell lineages.

Immune response in the intestinal mucous is mainly excreted by the gut associated lymphoid tissue [32]. Genetically predisposed patients when exposed to certain environmental factors activate immune responses against microbials or self-antigens which in turn, may impair the mucosal barrier of the intestinal mucosa, the first physical barrier on the mucosal surface.

Both the adaptive and the innate immune cells are present in the intestine, right below the epithelium. On IBD due to antigen translocation into the lamina propria, the immune response leads the adaptive cells to generate immune response to harmless components of the intestinal microbiota. This initial response induces a local increase in the production of pro-inflammatory cytokines and mediators which damages the mucosa. Therefore, the loss of integrity on this barrier enables the intestinal luminal bacteria to access the intestinal epithelium and to interact with the immune system underneath it more directly [33].

The intestinal epithelium is another line of defense against bacterial invasion. Intestinal epithelial cells play a key role in controlling the integrity of the physical barrier to the intestinal microorganisms [33] not only physically but also

secreting antimicrobial peptides and defensins, both of which are altered in IBD patients [34]. The intestinal epithelium also plays a key role on the intake and diffusion of metabolites from the intestinal lumen to the lamina propria.

Damaging or increasing the permeability of the intestinal epithelium results on a response from the immune system. Detecting signals of any foreign particle can also trigger the immune system. On the intestine this starts with the identification of these signals by intestinal epithelial cells have pattern recognition receptors. There are two main pattern recognition receptors: toll-like receptors (TLR), which are present on the surface, and nucleotide-binding oligomerization domain-like receptors (NOD-like receptors), present on the cytoplasm of the cells. These receptors upon recognition of pathogen associated molecular patterns (PAMPs) start an amplifying signaling producing chemokines and cytokines which activates the transcription and translation of pro-inflammatory mediators to ensure an effective immune response. Initially the innate response is triggered but the cells also increase the antigen presentation to T cells and thus activate the immune adaptive response [35].

Other cell types, such as monocytes, macrophages and dendritic cells also present the pattern recognition receptors. From those, macrophages and dendritic cells are antigen presenting cells too and secrete several cytokines to activate other immune cells. Usually CD patients express higher amounts of TLR than healthy individuals, which might trigger a stronger immune response. This response is driven by $CD4^+$ T cells proliferation in secondary lymphoid tissues to T helpers in the presence of the antigens and cytokines nearby.

T helpers (T_h) differentiate depending of the cytokines at which they are exposed. T_h1 are driven by exposure to IL-12 secreted primarily by dendritic cells. T_h2 are driven by cytokines secreted by macrophages. The imbalance between T_h1 and T_h2 -promoting cytokines determines the intensity and duration of the inflammatory response in experimental colitis [36].

T_{h17} -promoting cytokines are less well characterized in human. T_{reg} cells differentiate after exposure to cytokines IL-10, IFN- γ and TGF- β . Overall the presence of certain cytokines and the response to self-antigens are factors leads to an inflammation and damage that is related to the onset and establishment of IBD

On these kind of diseases autologous hematopoietic stem cell transplantation has shown some benefits on IBD [37]. The benefit of hematopoietic stem cell transplant (HSCT) in autoimmunity is thought to originate from the depletion of auto-reactive cells regardless of their specificity. However, due to its associated risk this therapy is only given when patients are refractory to all available therapeutic options.

1.1.1.4 Environmental

Chronic inflammatory disorders and neoplasms have become the main cause of morbidity and mortality in the countries with high standards of personal cleanliness. A decrease in human exposure to microbes or hygiene which might

affect the proper maturation of the immune system so that it provides less immune response or exacerbated response towards “friendly” microbes [38, 39].

From other environmental factors related to IBD such as tobacco, diet, certain drugs and stress; tobacco is the most influential environmental factor. Surprisingly, it has an opposite effect on UC and CD: in CD tobacco is a risk factor that increases the risk of relapse and/or surgical intervention. In UC, it has been observed that smoking cessation worsens the disease [40].

Pharmacological treatments such as oral contraceptives, non steroidal anti-inflammatory drugs are also related to develop or relapse the disease [41, 42].

The psychological welfare of people also plays an important role in the disease progression, stress, anxiety and depression might be important in relapse and deterioration of the disease [43]. Other environmental factors have been linked to IBD but without enough evidence to support a causative effect in the development of the disease.

1.1.2 CD physiology

As previously introduced, CD is a chronic inflammatory disorder characterized by a discontinuous inflammation of the gastrointestinal tract. Inflammation on the gastrointestinal tract is transmural and can affect from the mouth to the anus, but mainly it manifests on the ileum and colon [9]. It is frequently associated with extraintestinal manifestation and/or concomitant immune-mediated diseases.

The disease itself manifest an heterogeneous symptoms that can involve, diarrhea, weight loss, abdominal pain, fever, anorexia and malaise. Other less frequent co-occurring manifestations are arthritis, primary sclerosing cholangitis, skin disorders venous or arterial thromboembolism and/or pulmonary involvement [44] . These symptoms make it hard to correctly diagnose the disease by non-specialists, in addition there is not a non invasive easy procedure to diagnose it. All these can lead to delays on correct diagnosis of the disease.

The detection of parasites or bacteria, such as *Clostridium difficile*, have been associated with CD [45]. The detection of fecal calprotectin, is generally a good marker of endoscopic activity with sensitivity above 70% and specificity above 80% [46, 47].

Usually the best diagnosis method is to perform a colonoscopy, whether there is inflammation on the gastrointestinal tract on discontinuous regions then is CD. This inflammation could also present ulceration with rectal sparing and histological lesions which also help to diagnose the patients [48].

Usually on CD a granulome, that is a region with big multinucleous cells, can appear on any intestinal layer. In addition to the inflamed location(s), mosaic zones (patches of inflamed and non-inflamed areas) are more characteristic of CD [49].

The Montreal classification aims to classify patients according to their age of disease onset, standardized anatomical disease location and disease behavior. This classification assumes that the location of CD remains stable over time

after diagnosis but behavioral phenotypes change. Other scores consider area affected:

- Montreal classification allows for early onset of disease to be categorized separately those with age of diagnosis at 16 years or younger, diagnosis at 17–40 years and >40 years, respectively [11].
- SES-CD: simple endoscopic score for CD [50]. Score based on size of ulcers, ulcerate surface percentage, affected surface and presence of narrowing on the bowel.
- CDAI: CD Activity Index takes into account weight, ideal body weight, sex, and events on the last week such as liquid stools, abdominal pain, general well-being and if anti-diarrhea drug usage, as well as knowing if there are fistulas, fever, and other complications [51]

To some extent, there is a disassociation between clinical symptoms and the endoscopy finding. Often patients report feeling better despite lack of muscular healing [52]. To overcome this disassociation and be able to compare the well-being of patients several scores and thresholds are used on research and by physicians that will be described later.

In the early stages of the disease the relapsing and remitting course is more frequent. Often relapses are accompanied by clinical symptoms, and few have prolonged clinical remission (without treatment) [53]. When there is clinical remission, there can still remain some other lesions and often subclinical inflammation persists. Frequently the damage caused by the disease evolves to fibrostenotic stricture or penetrating lesions (fistula and abscess).

Damage of the disease might not be apparent to patients and might be only seen several years later than the first detection [52]. Mucosal healing is a first step towards the healing of deeper layers of the inflamed bowel wall on the CD.

Patients might progress from an inflammatory phenotype to a stricturing or penetrating one [11]. Stricturing is a narrowing of a part of the intestine often because of scar tissue and fibrosis in its wall. Penetrating is when the epithelium has some holes or tubes. If these tubes result in an abnormal connection between two body parts it is a fistula, it might also result in an abcess, a collections of pus, often developed in the abdomen, pelvis, or around the anal area.

1.1.3 UC physiology

As previously introduced, UC is a chronic inflammatory disorder characterized by a continuous inflammation of the colon. Depending on the inflamed segments of the intestine it is classified in several phenotypes.

Around a third of the patients with UC suffer proctitis, the inflammation of the rectum. If the segments from rectum to the sigmoid colon are affected is a distal colitis, if it affects the left colon then it becomes a left colitis. If the inflammation continues to the descending colon it is then an extensive colitis until it affects the whole colon when it becomes a pancolitis. The extension of UC is inversely related to the frequency. However, the extension and severity

of the disease correlates: the prognosis is worse the more extended it is [54]. In addition, the damage usually consists in many neutrophil in the lumen crypt [49].

The goal of the clinical care is to recover. As a first step, the symptoms of IBD have to lessen to the point that they are mostly absent, gone, or barely noticeable, this is known as clinical remission. However, this is not enough as the mucosa might be still inflamed and thus the reconstitution of the structure and function of the intestinal mucosa is not complete. Other lesions, might aid to the progression to other phenotypes such as fibrostenotic stricture or penetrating lesions or primary sclerosing cholangitis [55].

To prevent and avoid further damage several procedures are followed:

When there is dysplasia, an abnormal development of cells within tissues or organs (which is considered a precedence before colorectal cancer growth [56]), or the damage on the colon has been too big a surgical procedure to remove part or all of the colon must be done.

Patients that undergo a colectomy need to have their bowel reconnected with a procedure called ileoanal anastomosis (also know as J-pouch by the shape it takes) surgery. Often the lining of the pouch created during surgery becomes inflamed on what is known as pouchitis [57].

Many scores have been proposed for several purposes, from quality of life to disease severity or patient status. Among the scores most used are the following:

- Mayo: A score designed to be simple to calculate based on stool frequency, bleeding, mucosal appearance at endoscopy and physicians assessment [58].
- IBDQ: A 32 questionnaire used to assess the quality of life grouped into four categories: bowel, systemic, social and emotional [59].
- UCEDIS: An endoscopic score based on vascular pattern, internal bleeding and erosion and ulcers [60].

Other measured parameters include, weight, effective weight, fecal calprotectin, C reactive protein and hemoglobin.

1.1.4 Treatment

Current treatment attempt to induce and keep the remission of patients and reduce secondary effects of the disease instead of revert the pathogenic mechanisms. As standard of care corticosteroids, aminosalicylates and immunosuppressor and some other drugs like antibiotics or metronidazol are util in some cases.

Acid 5-aminosalicylic (5-ASA or mesalazina, pentasa) can be given in a topic way (either liquid, enemas, or suppository) or in oral form (pills or dilutions). In CU it helps in the clinic remission but it does not always mean that there is remission (is twice much likely than placebo to reach remission) [61]. On CD

the effects are not so stark and generally it does not produce changes on the disease [62].

Antibiotics, such as metronidazol and ciprofloxacina, are effective to deal with secondary effects of IBD such as abscess and bacterian overgrowth in CD [63, 64], but they do not seem effective on UC [64].

Corticosteroids can be taken orally, such as prednisolona, prednisona and Budesonide; intravenous, hidrocortisona, metilprednisolona; or via enemas and suppositories. Budesonide is not absorbed well and has a limited biodistribution but it has good therapeutic benefits with a reduced systemic toxicity in IBD [53, 65]. These drugs work very well as antiinflammatory for mild or severe IBD but do not work well as maintenance drug [66, 67].

Thiopurines (Azathioprine, mercaptopurina) are immunosuppressants drugs that deactivate key process of lymphocytes T that might trigger the inflammation. As a side effect they are toxic due to their interaction with nucleic acids [68]. on CD they are useful to induce and keep remission [69], while on UC they are used to keep the remission [70].

In the last two decades IBD treatment has moved from aminosalicylates, corticosteroids and immunomodulators to anti-TNF α . Anti-TNF α drugs has changed IBD treatment as it reduced the hospitalization associated with previous treatments, reducing medical costs and risk of surgery as well as induce a better mucosal healing and quality of life for patients [71]. However, 20-30% of patients have no response to this treatments and another 30-40% lose response in a year [72].

Recently a new wave of drugs has been developed targeting different molecules such as vedolizumab, targeting anti-integrin $\alpha 4\beta 7$, ustekinumab, targeting both IL-12 and IL-23, risankizumab an anti IL-23, tofacitinib an inhibitor of JAKs, infliximab an anti-TNF α .

Patients might become refractory to drug. Thus, drugs do not have the same effect as previously and the dose might need to be increased with the risk of more secondary effects [1]. Surgery resection might be needed on these patients.

Close to 35% of patients with UC will need to have a surgery resection, either due to complications or because the inflammation can not be controlled. Surgery usually removes the inflamed segment of the colon. The most common procedure used is a colectomy (whole colon removal), with ileostomy [73]. CD patients usually require surgery associated to complications like stenosis, abscess, and fistulas) between 70% and 90% at some point of their lives [74]. Usually the surgery is limited to removing the inflamed segment but occasionally an ileostomy is required [75].

If the drugs fail to contain the inflammation and heal the mucosa doctors might recommend a different procedure. In some cases HSCT is recommended which have shown to improve the life of the patients [76]. This is a new procedure given only to the most extreme cases to reset the immunological state of the patient.

To reset or hugely modify the microbiota fecal microbiota transplantation between different people is currently being explored [77].

1.1.5 Summary

IBD is a complex disease that impacts the health of many people for long time and with lasting impact on their quality of life.

Current clinical care in some cases is enough to have a sustained clinical and endoscopic remission but most often is not enough and relapse is expected. Several factors, such as becoming refractory to drugs, intermittent course of the disease and lack of validated predictors of disease course or response to therapy make the treatment complex.

Lack of knowledge of what are the factors cause of the disease make those treatments and drugs to be addressed to block further inflammation and damage, but cannot prevent it and often they do not stop it completely.

1.2 Integration studies on IBD

Many studies have looked up to the origin of the disease. As seen, one of the hypothesis behind the maintenance of the inflammation involves the microbiome and the host epithelium. This has been studied using several data sources, mostly from sequencing data. The technical methods used to obtain the data of the inflamed tissue differ between extracted from biopsied samples at colonoscopy or from surgical samples.

Those samples are usually used later on to diagnose or for research purpose. To obtain research-quality data it usually imply using techniques such as immunohistochemistry, histopathology, immunohistochemistry, fluorescence in situ hybridization and polymerase chain reaction. These techniques allow to measure or visualize where are the cells expressing certain proteins or genes, thus helping with the analysis validation.

Furthermore several studies have been carried out to discover links between microbiome and the inflammation, followed by those looking for some relationship between genetics and the disease and more recently the metabolome. These studies, known as integration, multi-omic or interaction studies, usually use multiple sequencing assays as the bases of the analysis [78].

However, confirming causal interactions of the variables of each essay is difficult. To find relationships some articles use correlation [79], there are others that use a combination of methods from correlations, partial correlations to integrative methods [80–82] and network integrations [81].

Very rarely there is an experimental confirmation of the relationships between variables of the different assays because it is complicated to test an interaction and to set up the right conditions for the many variables that are accounted for on the integrations. One of the few methods published that shows an interaction between genes and microorganisms on IBD is to expose the *ex-vivo* sample or cell lines with microbiomes or supernatant of at their culture [83].

1.2.1 Type of data used for integration analysis

According to the data used, we can classify the studies:

1.2.1.1 Transcriptome

Most of the integrations refer some other source of data to the transcriptomics of the patient. The transcriptome of patients derived samples has been extensively studied since the existence of microarrays. There are known marker genes of inflammation and many research focus on identifying prognosis predictors and treatment response prediction based on gene expression [84–86]. Recently single-cell RNA-seq technology has enabled to estimate cell populations of the samples with better degree of success than bulk RNA-sequencing. Single cell technologies are starting to be used for integration.

1.2.1.2 Microbiome

Many of the integration analysis on IBD are done between host transcriptome and the microbiome. These studies use datasets from IBD patients usually stratified by disease activity or severity of inflammation or location of the disease. Most of them are based on correlation analysis between the microbiome and RNA-seq [79]. Conclusions of these integrations range from finding differences on the correlation depending on the type of disease ([79]) to finding relationships with inflammatory genes [80].

1.2.1.3 Genetics

Genetics is the next most common data source used to integrate data on IBD. Most studies on genetics and IBD are genome-wide association studies. The genetic component is specially important on IBD that starts on children [13, 82, 87].

When using genetic data to integrate it with transcriptomics it is usually to understand how a genetic variant is affecting a gene expression. This has lead to the identification of expression quantitative trait loci (eQTL) [88–91].

1.2.1.4 Metabolome

More recently there have been an increased interest on the study of the metabolic state of IBD patients, given that microorganisms interact with the host also via their products and metabolites. There is evidence some of these metabolomic products come from the microbiome [24, 83]. Some studies have integrated the metabolome with the RNAseq and state of the epithelium [92, 93].

1.3 Integration

The term “data integration” is widely used with varying meanings. According to the dictionary integration is defined as:

“the process of combining two or more things into one” — [Cambridge Dictionary](#)

Other words used are integration, and if specific to data from sequencing technologies, multi-omics or pluri-omics. Here integration will be used as it is the more general one and not restricted to omics or sequencing technologies.

Since the beginning of the integration methods there have been many methods proposed [94]. Some of the early methods were initially used for surveying the agreement of different evaluating systems [95], others were developed for agricultural sciences [96] or food industry [97]. Some of these methods are specific for one application or data type while others are more generally applicable. Lately, the access to bigger datasets with more variables and often from the same samples has increased the focus of the research community on the methodologies available on several disciplines but mainly on biological sciences. The explosion of data on biological sciences has been driven by the new sequencing technologies that allow to measure thousand of variables of many samples at the same time. If done with multiple sequencing technologies it is usually referred as multi-omics methods, which usually only uses omic data.

It is crucial to classify, review and compare tools available, as well as, to benchmark these tools against the same dataset as a way to provide clear recommendations to anyone wishing to use them [98]. Part of these efforts use the methods’ strategies to classify them [99, 100]. Following this view I will review the available integration methods according to several axes: type of data used, aim of the method, relationships between variables, relationships between samples, relationship between variables and samples, input data, mathematical framework and results of the method.

1.3.1 Classification of integration method

Integration methods have very different properties that allow them to be classified and compared. Here I classify those meant to be used with omics datasets, with references to concrete methodology and in occasionally to articles using them.

1.3.1.1 Data type: numeric or categorical

The most important distinction in integration methods is what kind of data are combined. In general data can be divided between categorical and numeric variables, which are usually found in several fields. Sometimes clinicians want to understand the relationship between a phenotype they observe and the underlying mechanism. Usually this involves looking how metabolites, gene expression,

methylation, number of variants a gene has, and other numeric variables are related to the observed phenotype (i.e. pain).

Depending on the method's aim it handles numeric and categorical data types or just one. Often they are used differently. The most common way to handle different types of data is converting the categorical values to a mock or dummy variable. For each categorical factor there is a new variable whose value is 1 if that sample had this factor and 0 otherwise. For instance, if the categorical variable has three values (A, B, C) it would be converted to A (1, 0, 0) B (0, 1, 0) and C (0, 0, 1). Often the number of variables created is one less than the number of factors that existed, on this example only A and B would be kept. This transformation allows to use categorical values as numeric variables.

If the method only accepts categorical data but you want to provide numeric values usually those values are categorized. For example if a variable is (0.123, 0.25, 0.56, 0.78) one could make to categorical values like (“<0.5”, “<0.5”, “>0.5”, “>0.5”). The number of categories to use and how the numeric value splits depends on each case.

Very rarely methods allow to use both data types as they are. If they allow so, it is usually for classification purposes only.

1.3.1.2 Objective

The objective of any method is one of its most important defining properties. Data integration can be classified according to the (biological) question they try to answer. In general all of them aim to provide a better understanding of the relationships between the 'omics types. Often a single method is not enough and several methods are used on the same dataset. This is specially relevant when a potentially relationship between omics is discovered. For instance, checking that in a particular case or condition a given relationship is present, might require experimental confirmation.

Most of the times one (or several) of the following results are expected from integration methods:

- Classification of the patients or samples

One of the purposes of integration might be to use multiple sources of data to accurately describe how do samples or patients fit on a predefined possible states. The objective here might be to accurately describe whether a patient has one or other related disease of a possible subset of diseases or phenotype [101].

- An overview of the role of each individual omic in a biological system

Sometimes the question is which omic method is the best describing a disease. This knowledge could prevent performing expensive tests and replace them by more affordable or easier technique that has enough predictive power or is sensitive enough and specific for the task. An example of this is the search of markers on blood to identify links between different cell populations [80, 102].

- Finding a molecular signature

A signature is usually a group of features that describe/are representative of a cell type, a process or a stage. Identifying a subset of variables from the omics that are related is often a desired goal because it reduces the amount of variables allowing to perform experiments on the bench on just those that might be important. In other fields, such as machine learning, selecting the important variables is known as [feature selection](#). There are several methods that are used to do this [99]. An example of this is when performing eQTL analysis, where a locus is related to a change in gene expression [88–91].

- A predictive model

Predictive models usually require a very good understanding of the current and/or past relationships, as well as, a good feature selection procedure. If a good model on previous data exists it might be used to predict future events. Sometimes, models are only built to predict events without being able to accurately understand the underlying mechanism. This kind of methods are used to improve treatment selection, diagnosis and prediction of prognosis [103].

- Impute values

Some methods aim to accurately guess the values of missing data given some other information. Missing values can happen for a variety of reasons from practical ones, like a sample not being available, to technical ones, such as laboratory mistake [104]. However, this is often a intermediate step to other goals.

To complete these goals it is important to have enough statistical power to determine the significance of tests performed (if any) and to understand how complete are the data sources used on the integration [105]. Having more statistical power helps identifying the relationships one seeks when using this methods.

1.3.1.3 Relationship between variables and samples

Depending on the amount of variables and samples used in studies can be classified in two types. Traditionally for each sample few variables are measured, for instance on a biopsy with RT-PCR only a few genes are measured, however with the new omics techniques (transcriptomics, metabolomics, methylomics, genomics), thousands of variables are measured for the same sample. This has lead to the following situation:

- More variables than samples

For a single sample of RNA around 50k genome identifiers (genes, long non coding RNAs, iRNA, pseudogenes,...) can be measured. Which leads to the case where there are many more variables than samples. Thus high-throughput data analysis typically falls into the category of $p \gg n$ problems (big p, little

n), where the number of genes or proteins, p , is considerably larger than the number of samples, n . With such high number of variables the identification of the relevant variables is hard because variables will co-variate. When many variables are tightly correlated, discovering which one is important using just numerical methods is challenging. This is even more difficult when looking for causal relationships.

- More samples than variables

This was the usual case when for instance, from a cohort of patients the temperature is measured along the stage of a disease: two variables, time and temperature for each sample. If there are more than 2 patients, then the number of samples is greater than the number of variables studied. This is described in the literature as $n \gg p$ (or big n , little p). Nowadays this is less frequent on the bioscience world, and does not causes trouble analyzing it because the high number of samples allows to accurately estimate the dispersion of variables.

There are several methods available to estimate the number of samples required [106]. Having just the enough samples for the desired statistical power, however, might not be enough in case some samples are not correctly processed.

In addition, variables might be separated on different blocks of variables. These blocks might be just of the same source or from multiple methods. Depending on the method this blocks might have special meaning: when all the data is joined in a single block it is known as superblock.

1.3.1.4 Relationship between samples

Depending on the relationship between the samples, the questions answerable and the methods that work on them differ.

A sample can have multiple or one data source, for instance we could have RNA-seq and 16S data from the same sample. In a study if all the samples have all the data from multiple data sources it is a complete case. If some samples have data from some data sources but not from others the study is not a with a complete case.

Sometimes because the sample is not enough, or there are some technical or organizational problems a source of data for a sample (which is known as an incomplete case) might be lost. This results in a new source of variation that has to be dealt with, which complicates the conclusion one can draw from the studies of these kind of data.

Even when all the cases of a patient are complete the samples can come from several sites of the same individual or with different combinations of variables, which makes it relevant to understand the relationships between the different samples.

There is no easy classification of this as each experiment might be designed differently. In general, experiments are designed to be as consistent as possible but in face of adverse events that become a variation of the design the analysis complicates. Either some data is imputed or some samples are omitted for the

analysis. This can happen with samples taken at different timepoints as patients for instance if they miss a follow up visit.

Time As mentioned above, time is one of the factors that sometimes cannot be controlled, despite having programmed visits every two weeks, for instance, some patients might come early or later due to multiple reasons.

Sometimes, the objective of the study is precisely to analyze the relationships at different time, or to asses how the relationships change with time. To discover causality between two variables the cause must precede the consequence, which highlights the importance of time. Being aware of the time differences and time scales is crucial in most cases.

During *in vitro* experiments, conditions can be reproduced even if they are at different time. However, when using patients material replicates can not usually be performed like *in vitro* experiments. This makes it harder to study time-related change on patients.

Lastly, time between the collection of a fresh samples and its processing also influences the readings of the samples of the omics technology, specially RNA-seq [107, 108]. Some genes are more influenced by time than others but as they are measured at the same time in all samples this might distort the data. Keeping track of the time that it takes to process samples is also hard to due and requires a highly coordinated effort [109].

1.3.1.5 Relationship between variables

Once data is collected, the next step is to understand the relationship between the variables present. As mentioned earlier, some variables influence others which can affect the outcome in complex ways. With many variables present in a dataset it is important to be aware of known relationships between variables. Even in a simple dataset, like an RNA-seq dataset, it is important to be aware of the relationships between variables.

Since the discovery of the lactose [operon](#) it is known how some genes regulate each other [110]. However, it is not know how other variables are related between them. For instance, how does the increase in expression of a gene affects the growth of a microorganism? Usually the relationships between variables are mediated by many factors or interactions.

One of the best examples of such interactions is when some variables correlate. Their correlation can be used to reduce the number of variables being analyzed by ignoring the relationships between them and using the most representative variable (less widely correlated and with more variation). This step is usually done by dimension reduction methods. However, sometimes this is not desirable or feasible as the correlation does not explain the direction of the causality of the interaction between the variables (if there is any).

Network approaches relate the variables to each other [111]. These approaches are fairly new and growing in popularity partly because they can address the direction of the interaction.

In partial correlations the effect of other variables on the two being under study are taken into account [112]. They assumes a linear relationship between the co-occurring variables and those of interest. However, it is computationally expensive when there are thousands of variables.

1.3.1.6 Input data

We have classified the studies according to the data they use (as seen previously). But, some methods to account for relationships of variables only work when a dataset is complete while other do not:

- Data from the same samples:

These methods do not handle well or at all missing data. They need complete cases/data of the samples in order to be able to integrate the results. These methods include Regularized Generalized Canonical Correlation Analysis (RGCCA) [113, 114], Multiple co-inertia analysis (MCIA) [115], Multi-Study Factor Analysis (MSFA) [116], Multi-Omics Factor Analysis (MOFA) [117] and STATEGRa [118].

- Data from different samples:

These methods do not need data from the same sample. They draw their conclusions generalizing from the data available. Some of them handle missing data, while others do use the data at face value. These method includes MetaPhlAn2 [119], HUMAnN,[120] and LEfSe [121].

Furthermore, some methods are designed to integrate specific types of datasets, (usually because they make some assumptions that are only met on that kind of data). For instance, HCG, 16S rRNA-seq, RNA-seq and metabolomics do not share the same data distribution, and are different between them. Also even with the same data depending on the processing of the data they can have very different properties: OTUs (operational taxonomic unit) properties are not the same as ASV (amplicon sequence variants) when analyzing 16S rRNAseq data.

1.3.1.7 Mathematical framework

Methods use different mathematical frameworks to process the data. Here I briefly describe some common mathematical frameworks, some of which have previously appeared:

- Networks

Networks methods were mentioned because they use and find information about the interaction of variables. Multilayer networks, including the multiplex, Molti-C-DREAM [122], Random Walk with Restart on Multiplex and Heterogeneous Biological Networks RWR-MH, Random walk with Restart on Multiplex RWR-M [123]. Network embedding MultiVERSE are some of the methods using networks [124].

Bayesian approaches are also quite frequent, these methods use the Bayes' theorem to see the relationships between variables. The Bayes' theorem explains that the conditional probability of a variable is related to the prior knowledge of conditions that might be related to the event [125]. Some methods that use these approaches are Reconstructing Integrative Molecular Bayesian Network ([RIMBANET](#)) [126] and Bayesian Consensus Clustering ([BCC](#)) [127].

- Dimensional Reduction

These methods focus on finding just a few variables and summarizing them using a function that has some desired property such as the correlation between three transformed variables is maximal while the components are orthogonal. The selection of variables is usually done with L1 or Lasso Regression regularization technique or L2 also known as Ridge Regression. L1-regularization adds a penalty equal to the absolute value of the magnitude of coefficients which might lead to some coefficients becoming zero and the variable eliminated from the model. On the other hand, L2-regularization does not result in elimination of coefficients or sparse models and can only be used when there is multicollinearity as it works well to avoid over-fitting.

Several tools use this approach, Momix [128], regularized canonical correlation analysis (RGCCA) [129], mixOmics [130] and STATegRa [131]. Other methods use bayesian approaches like the Bayesian Group Factor Analysis [132].

- Active module identification

Multiomic objective genetic algorithm (scores based in two metrics; node score and density of interactions score). An example of a method using this approach is Multi-Objective Genetic Algorithm to Find Active Modules in Multiplex Biological Networks ([MOGAMUN](#)) [133]

Usually depending on the mathematical framework used, these methods return similar outputs.

1.3.1.8 Output results

According to the output the integration methods can be classified in several groups:

For the network methods the following output is usually returned: Connections between the variables/nodes, a measure of how strong is the connection (or simply if there is a connection or not).

For dimensional reduction methods there are three possible outputs: Shared factor across the data, specific factors for each data or mixed factors.

- Shared factors:

Integration results in a vector of the samples in a lower dimensional space that is shared by all the data set used to integrate. Such methods include iCluster, Multi-Omics Factor Analysis (MOFA) [117].

- Specific factors:

Integration results in several vectors of the samples in a lower dimensional space of each data set used to integrate. Such methods include Regularized Generalized Canonical Correlation Analysis (RGCCA) [113, 114], Multiple co-inertia analysis (MCIA) [115] and Multi-Study Factor Analysis (MSFA) [116].

- Mixed factors:

Integration results in both shared and specific factors, to each dataset and common to all them. Such methods include Joint and Individual Variation Explained (JIVE) [134] and integrative Non-negative Matrix Factorization ([iNMF](#)) [135].

1.3.2 Interpretation

How to interpret the results of applying the different methods is highly linked to understanding the method and its output. On a correlation between two variables, the interpretation of the analysis is clear, if one variable increase, the other one too. The implications of this correlation can be far reaching but the principles to understand them are simple.

However, on more complex methods the interpretation becomes less clear. The interpretation of a canonical correlation analysis is much harder [136]. Also on more complex methods the number of parameters required increases so the time and intellectual effort to understand the relationships between the parameters is also higher.

The interpretation also helps to discuss the results and relate it to other previously known information.

- Individually:

Here we study how each variable relates to another. In the correlation analysis, the relationship between two variables under study. Or if looking by patient: how do interpret that in these patient variable A and B is X and Y?

- Globally:

In a principal component analysis for instance how do we interpret that some variables have the same loading? What happens in a more complex method like canonical correlation analysis?

There are some articles about how to interpret those methods on real datasets [137]. Others, to benchmark and to learn how to interpret propose analyzing

a simulated dataset [138, 139]. Which is used to compare the results of the integration with the dataset of interest and to compare different tools. These datasets are created with some relationships that the tools are expected to find.

There exists several methods to create synthetic datasets like MOSim [140], metaSPARSim [141], CAMISIM [142], ballgown [143], polyester [144] and even edgeR [145]. These methods are useful to compare different setup but they can miss some subtle not previously reported relations on real data.

1.3.3 Reviews

The comparison and review of methods independently from original authors have become a crucial step for selecting the right tool to apply a given dataset and research question [128].

Some of these reviews focus on a specific type of data integration: metabolomics [99], genomics [10], microbiomics... Others focus on the disease and the challenges of each omics and the need of an integrative approach to provide better therapies [105, 146, 147]. On this regard there are several efforts to integrate data on IBD but no comprehensive review to date is known to the author. The most comprehensive article to date is a very recent review identifying problems and providing recommendations for future work [148].

1.3.4 Summary

The field of integration is large and complex, with increasing interest over the last few years, specially in the psychology and omics fields. As a methodology they are quite complex and diverse but there is a growing interest on them to help answer complex questions without using other complex tools like deep neuronal networks or other machine learning approaches (despite not being incompatible).

Methods to integrate have many characteristics, depending on the objectives and data that available. Regardless of the method used, interpretation and reporting is usually the main challenge.

Chapter 2

Hypothesis and objectives

2.1 Hypothesis

I hypothesize that the presence of certain microorganisms are related to the patient well being. Furthermore, the expression state of the epithelium and the amount of bacterial presence might identify whether patients are suffering an IBD. Finally, I believe that environmental factors interact with the IBD and are responsible of the big variability on the IBD discourse.

2.2 Objectives

The main objective of the thesis is finding the relationships between microbiome and gene expression in the intestinal mucosa. For this reason we identify microorganisms and genes related to the IBD.

- Identify how is the relationship between the intestine mucose gene expression and the microbiome present on the intestine.
- Find the influence of variables such as location (colon and ileum), the treatment received, IBD activity, sex, age, etc. in the microbiome and mucosa relationship.
- Identify possible mechanism of interaction between the microbiome and mucosa

Chapter 3

Materials and methods

This chapter contains a brief description of the main characteristics of the different datasets used on this thesis . The complete processing protocol before obtaining the data of those dataset that were not generated at Hospital Clínic can be found on their respective reference.

Samples of the different cohorts collected in Hospital Clínic were collected similarly and described only once. Differences between protocols are noted on the respective dataset's section.

Here we describe all the methods used to analyze data from the multiple cohorts included in this thesis. The code used can be found on the links provided in the [appendix](#).

3.1 Datasets

3.1.1 Puget's dataset

The glioma dataset is the data provided as an example of biological data by the authors of RGCCA from a previous publication [149]. The data came from diffuse intrinsic pontine glioma patients whose transcriptome was analyzed with Agilent 44K Whole Human Genome Array G4410B and G4112F. The copy number variation of the samples was processed with the ADM-2 algorithm, and data from comparative genomic hybridization (CGH) analyzed using [Mutation Surveyor software](#). In addition, this dataset contained information on age, localization of the tumor, sex and a numerical grading of the severity of the tumor [149].

Table 3.1: Characteristics of samples from Puget's dataset.

Characteristic	Puget's
Samples	53
Sex (female/male)	28/25

Characteristic	Puget's
Location (cort/dipg/midl)	20/22/11

3.1.2 HSCT dataset

Samples from the HSCT dataset used in this thesis were from a cohort of patients with severe refractory CD undergoing HSCT. Patients were treated in the Department of Gastroenterology (Hospital Clínic de Barcelona –Spain–). The protocol was approved by the Catalan Transplantation Organization and by the Institutional Ethics Committee of the Hospital Clinic de Barcelona (Study Number HCB/2012/7244). All patients provided written consent following extensive counselling about being included on the study and using their data on publications.

Colonic and ileal biopsies were obtained at several time points during ileo-colonoscopy, at inclusion and every 6 or 12 months after HSCT up to 4 years after the start of the treatment. Samples were obtained when possible from both uninvolved and involved areas. In addition, biopsies were taken from the ileum and colon regions of 19 non-IBD controls consisting of individuals with no history of IBD and who presented no significant pathological findings following endoscopic examination for colon cancer surveillance (Hospital Universitari Mútua de Terrassa –Spain–). The protocol was approved by the Institutional Ethics Committee of the Hospital Universitari Mútua de Terrassa (Study Number NA1651).

At least one biopsy was collected and fresh-frozen at -80°C for microbial DNA extraction. The remaining biopsies were placed in RNAlater RNA Stabilization Reagent (Qiagen, Hilde, Germany) and stored at -80°C until total RNA extraction. In total 158 samples with both RNA and DNA extraction of the same segment and time were available 3.2:

Table 3.2: Characteristics of samples from HSCT dataset.

Characteristic	HSCT
Sex (female/male)	22/15
Age at diagnostic (<17/<40/>40 years)	7/11/0
Duration (in years): mean (min-max)	14 (8-28)
Age: mean (min-max)	44 (23-70)
Disease status (non-IBD/CD)	51/107
Sample location (ileum/colon/unknown)	48/108/2
Local simple endoscopic score for CD: mean (min-max)	2.15 (0-12)
CDAI: mean (min-max)	120 (0-450)

3.1.3 Hässler's dataset

An IBD-related dataset was obtained by Prof. Dr. Rosenthal and Prof. Dr. Robert Hässler [79]. Biopsies were obtained endoscopically during routine diagnosis

RNA and DNA were extracted using standard procedures. DNA from the 16S rRNA gene was amplified with primers 319F and 806R. Both RNA and DNA was then sequenced on HiSeq 2000 and MiSeq respectively. These biopsies included samples from the terminal ileum and sigma from CD, UC, infectious disease-controls and healthy non-IBD. The dataset included information about gender, location, age, and the status (inflamed or non-inflamed) of the region from which the biopsy was taken.

Table 3.3: Characteristics of samples from Häsler’s dataset.

Characteristic	Häsler’s
Disease status (non-IBD/IBD)	33/26
Sex (female/male)	42/17
Sample location (ileum/colon)	30/29

3.1.4 Morgan’s dataset

A previously published dataset from a pouchitis study was analyzed [150]. In this study patients having undergone proctocolectomy with ileal pouch-anal anastomosis for treatment of UC or familial adenomatous polyposis at least 1 year prior to enrollment were recruited at Mount Sinai Hospital (Toronto, Canada) excluding individuals with a diagnosis of CD. The dataset has a total of 255 samples from 203 patients, containing data for both host transcriptome and intestinal microbiome. On some cases several biopsies were collected from the same patients. This dataset included anonymous identifiers for patients, whether the sample was from the pre-pouch ileum (PPI) or from the pouch, the sex, the outcome of the procedure and an inflammation score. The pouch ileum might be inflamed or not.

Table 3.4: Characteristics of samples from Morgan’s dataset.

Characteristic	Morgan’s
Samples (n)	255
Sex patients (female/male)	101/102
Sample location (Pouch/PPI)	59/196

3.1.5 Howell’s dataset

This dataset included a cohort of 66 treatment-naïve children at diagnosis of their IBD, along with 30 age- and sex-matched non-inflammatory control children, recruited at the Paediatric Gastroenterology unit at Addenbrooke’s Hospital (England) [151].

Data from 77 samples that had both RNAseq and 16S data was used. There are 10 non-IBD samples, 11 with CD and 11 with UC. Data has the following characteristics: disease, age at diagnostic, age at time of study, sex, sample location, and disease activity:

Table 3.5: Characteristics of samples from Howell's dataset.

Characteristic	Howell's
Disease (non-IBD/CD/UC)	11/10/11
Age at diagnostic (<17/<40/>40 years)	32/0/0
Age: mean (min-max)	12 (6-15)
Sex (female/male)	10/22
Segment (ileum/colon)	31/46
Clinical history (inflammation/no inflammation)	24/53

3.2 Sample processing

3.2.1 RNA sequencing

Total RNA from mucosal samples (HSCT cohort) was isolated using the RNAeasy kit (Qiagen, Hilde, Germany). RNA sequencing libraries were prepared for paired-end sequencing using HighSeq-4000 platform. Samples with good enough quality as recommended by [FastQC](#) were processed with [cutadapt](#) (version 1.7.1 [152]) for quality filtering. Later, the libraries were mapped against the human reference genome using the [STAR aligner](#) (2.5.2a) with Ensembl annotation ([release 26 of GENCODE](#), GRCh38.p10 or superior) [153].

Read counts per gene were obtained with [RSEM](#) (version 1.2.31) [154] as previously described [155].

3.2.2 Microbial DNA sequencing

Biopsies from the HSCT CD cohort were resuspended in 180 μ l TET (TrisHCl 0.02M, EDTA 0.002M, Triton 1X) buffer and 20mg/ml lysozyme (Carl Roth, Quimivita, S.A.). Samples were incubated for 1h at 37°C and vortexed with 25 μ l Proteinase K before incubating at 56°C for 3h. Buffer B3 (NucleoSpin Tissue Kit–Macherey-Nagel) was added followed by a heat treatment for 10 min at 70°C. After adding 100% ethanol, samples were centrifuged at 11000 x g for 1 min. Two washing steps were performed before eluting DNA. Concentrations and purity were checked using NanoDrop One (Thermo Fisher Scientific). Samples were immediately used or placed at -20°C for long-term storage until DNA sequencing.

3.2.2.1 DNA sequencing

Microbial cells were disrupted by mechanical lysis using FastPrep-24. Heat treatment and centrifugation were conducted after adding a cooling adaptor. Supernatants were treated with RNase to eliminate RNA. Total DNA was purified using gDNA columns as described in detail previously [156]. Briefly, the V3-V4 regions of 16S rRNA gene were amplified (15x15 cycles) following a

previously described two-step protocol [157] using forward and reverse primers 341F-ovh/785R-ovh [158]. Purification of amplicons was performed by using the AMPure XP system (Beckmann). Next, sequencing was performed with pooled samples in paired-end modus (PE275) using an MiSeq system (Illumina, Inc.) according to the manufacturer's instructions and 25% (v/v) PhiX standard library.

Library preparation and sequencing of the HSCT dataset were performed at the Technische Universität München. Briefly, volumes of 600 μ L DNA stabilization solution (STRATEC biomedical) and 400 μ L Phenol:choloform:isoamyl alcohol (25:24:1, Sigma-Aldrich) were added to the aliquots.

3.2.2.2 Microbial profiling

For the HSCT dataset the processing of raw-reads was performed by using the IMNGS (version 1.0 Build 2007) [159] pipeline based on the UPARSE approach [158]. Sequences were demultiplexed, trimmed to the first base with a quality score <3 and then paired. Sequences with less than 300 and more than 600 nucleotides and paired reads with an expected error >3 were excluded from the analysis. The 5 nucleotides from each end of the remaining reads were trimmed to avoid GC bias and non-random base composition. Operational taxonomic units (OTUs) were clustered at 97% sequence similarity. Taxonomy assignment was performed at 80% confidence level using the RDP classifier and the SILVA ribosomal RNA gene database project. Later the data was normalized using the same method as for RNA-seq described above. The microbiome was visually inspected for batch effects in PCA; none were found. The resulting OTUs table was normalized using edgeR (Version 3.28 or later) [145].

For all the other datasets [dada2](#) [160] (Version 1.14 or later) was used to analyze microbiome data. It creates amplicon sequencing variants from the 16S sequencing data, without merging similar sequences at any threshold. It is an alternative to the use of OTUs which allows to compare results between studies and provides more resolution to identify differences on the fragment of 16S amplified.

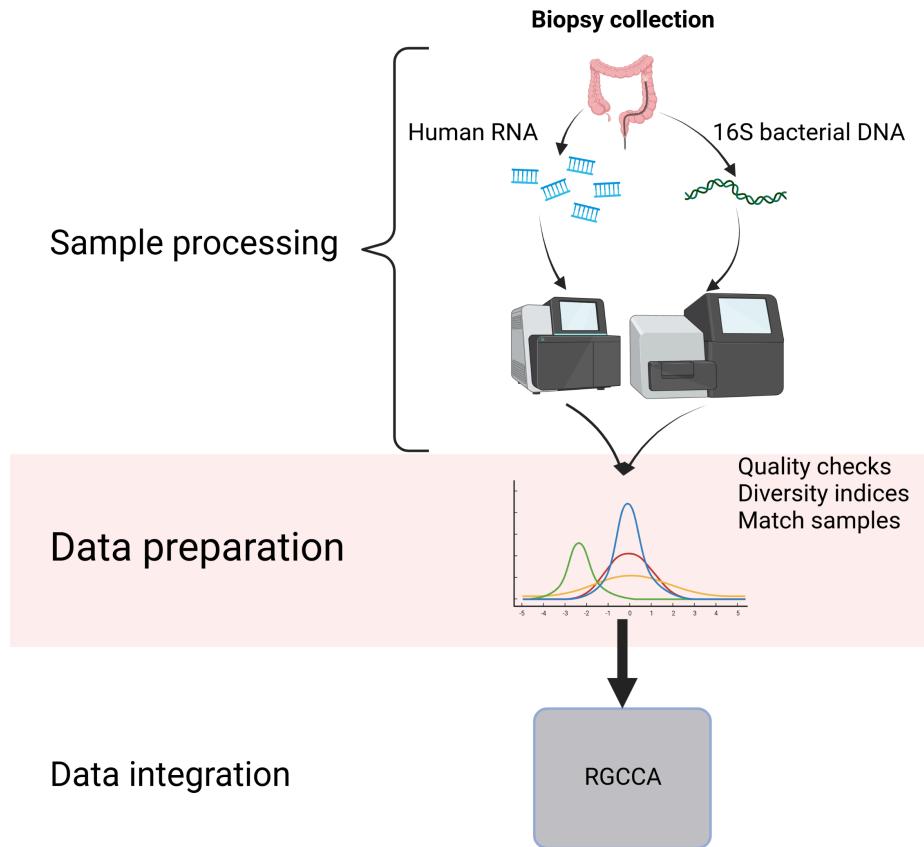


Figure 3.1: Workflow of the analysis process.

3.3 Integration methods

3.3.1 MCIA

Multiple co-inertia analysis, also known as MCIA, is a method to examine co-variant gene expression patterns between two blocks [161]. It is implemented on the package [omicade4](#). On its core MCIA maximizes the following formula:

$$\sum_{k=1}^K w_k \text{cov}^2(X_k Q_k u_k, v)$$

where K is the total number of matrices, X_k the transformed matrices and Q_k is a square matrix with r_{ij} in diagonal elements indicating the hyperspace of features metrics, u_k are auxiliary axes, v the reference structure and w the weights of the matrices. This can be used to obtain a dimension of $P_k^d =$

$u_k^d(u_k^d Q_k u_k^{dT})^{-1} u_k^d Q_k$ given that for each dimension the residuals are obtained following $X_k^{d-1} = X_1^d - X_1^d P_1^{d-1}$ where d are the dimensions needed.

MCIA was used as a baseline method to compare the RGCCA integration.

3.3.2 STATegRa

We used [STATegRa](#). To explore how much do different blocks of a dataset have in common [162]. It is a framework for integrating datasets with two data types using parametric and non-parametric methods. The methods used are omics component analysis based on singular value decomposition (SVD) of the data matrix. There are three different methods provided to this end: *DISCO-SCA*, *JIVE* and *O2PLS*.

DISCO-SCA uses:

$$X_k = TP_k^T + E_k$$

Where T is the $I \times R$ matrix of components scores that is shared between all blocks and P_k the $J_k \times R$ matrix of components loadings for block k .

Let X_1, X_2, \dots, X_i be blocks of data and $X = [X_1, X_2, \dots, X_i]$ represent the joint data, then the JIVE decomposition is defined as:

$$X_i = J_i + A_i + \epsilon_i, i = 1, 2, \dots$$

where $J = [J_1, J_2, \dots, J_i]$ is the $p \times n$ matrix of rank $r < \text{rank}(X)$ representing the joint structure, A_i is the $p_i \times n$ matrix of rank $r_i < \text{rank}(X_i)$ representing the individual structure of X_i and ϵ_i are $p_i \times n$ error matrices of independent entries.

Finally, the O2PLS approach uses multiple linear regression to estimate the pure constituent profiles and divides the systematic part into two, one common to both blocks and one not. The O2PLS model can be written as a factor analysis where some factors are common between both blocks.

$$\begin{aligned} \text{X model : } X &= TW^T + T_{\text{Y-ortho}}P_{\text{Y-ortho}}^T + E \\ \text{Y model : } Y &= UC^T + U_{\text{X-ortho}}P_{\text{X-ortho}}^T + F \\ \text{Inner relation : } U &= T + H \end{aligned}$$

Each model is built similarly by adding the subtraction of the projected values of the other component keeping the relationship between them as stated on the third line.

3.3.3 RGCCA

The main method used on this thesis has been regularized generalized canonical correlation analysis (RGCCA) a method derived from the canonical correlation. Canonical correlation is a method that uses data about the same unit but

from different origins to find how much the different sources agree. Regularized generalized canonical correlation analysis is implemented on the homonymous package [RGCCA](#) [129] which was used here. The method and implementation will be explained in detail in the next section.

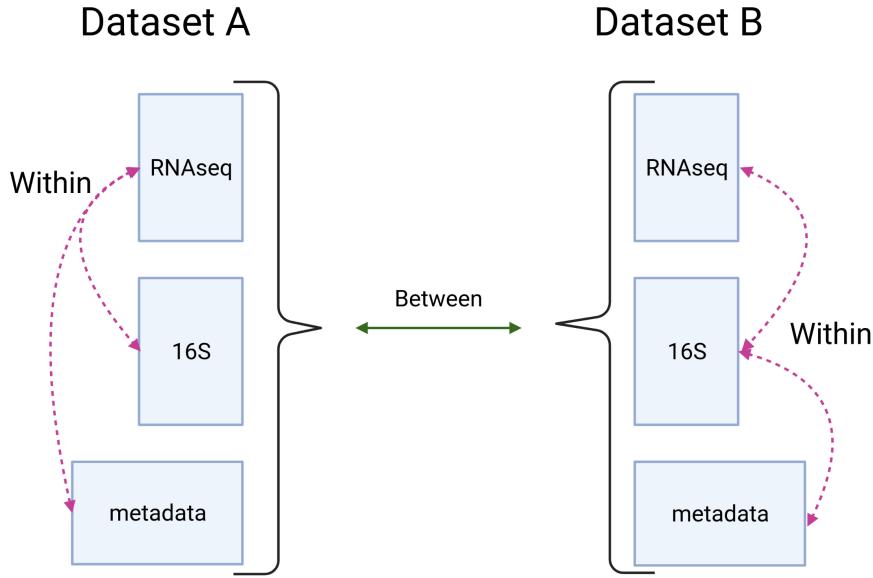


Figure 3.2: Multiomic relationships on different datasets. Integration methods focus on relationships within datasets. Common relationships between datasets are used as confirmation/validation.

3.4 Regularized generalized canonical correlation analysis

To understand the regularized canonical correlation analysis I first provide a brief description of principal component analysis.

Principal component analysis defines a new orthogonal coordinate system that optimally describes variance in a single dataset. It does so by decomposing the numerical matrix into the eigenvalues and eigenvectors with decreasing variance. Its results include new variables (the eigenvectors) and a vector of loadings or weight indicating the importance of the original variables for these new variables. Typically, data is normalized and standardized to avoid that a variable with higher variance and different scale dominate the results.

The canonical correlation analysis [163, 164] is a method to find agreement between two, or more, scorers (as it was first introduced on the literature) or sources. It extends the PCA to a two sources of data. It provides a simi-

lar output, new variables and weights of the existing variables indicating their importance. The function it maximizes is:

$$\rho = \underset{a,b}{\operatorname{argmax}}(\operatorname{cor}(a^T X, b^T Y))$$

On this equation a and b are random variables that given X and Y , the two data sources, maximize the correlation between $a^T X$ and $b^T Y$, the first canonical variables, the new variables. a and b are also known as weights or loadings of the variables.

Over several years of progress on the field of canonical correlations [113, 114, 165–169], regularized generalized canonical correlation analysis (RGCCA) emerged with a generalization from canonical correlations extending the procedure to more than two sources of data [R-RGCCA?] and being made more flexible generalizing from other proposed methods.

3.4.1 Description

RGCCA works with numeric matrices that can be as big as needed, as it is designed for datasets with more variables than samples ($p \gg n$). However, for each sample it needs to have a complete case with no missing values (at the time of writing this thesis there is an [in-development version](#), not released on CRAN¹ yet, that replaces any missing value by a 0) and in which time is not considered as a special variable. It uses a dimensional reduction approach to relate the different blocks of data between them and produce specific factors for each dataset. The objective function is:

$$\underset{a_1, a_2, \dots, a_J}{\operatorname{maximize}} \sum_{j,k=1}^J c_{jk} g(\operatorname{cov}(X_j a_j, X_k a_k)) \quad \text{s.t. } (1-\tau_j) \operatorname{var}(X_j a_j) + \tau_j \|a_j\|^2 = 1, j = 1, \dots, J$$

Being X_j the values from sample j , the weights of the variables of said sample are represented by a . While g is a function that can take the form of x , also known as Horst method, $|x|$ known as centroid method, x^2 known as factorial method, or any user-supplied function. C is a symmetric matrix describing the network between blocks.

The shrinkage parameter is defined as:

$$\hat{\lambda}^* = \frac{\sum_{i \neq j} \widehat{\operatorname{Var}}(r_{ij})}{\sum_{i \neq j} r_{ij}^2}$$

Where the r_{ij} are the correlation coefficients of the matrix between variables i and j . Where the variance is defined as:

¹CRAN is The Comprehensive R Archive Network available at <https://cran.r-project.org/>

$$\widehat{Var}(S_{ij}) = \frac{n^2}{(n-1)} \widehat{Var}(w_{ij}) = \frac{n}{(n-1)^3} \sum_{k=1}^n (w_{kij} - \bar{w}_{ij})^2$$

And its components are: $w_{kij} = (x_{ki} - \bar{x}_i)(x_{kj} - \bar{x}_j)$ and $\bar{w}_{ij} = \frac{1}{n} \sum_{k=1}^n w_{kij}$ representing x_{ij} the values of a sample j on a variable i .

The authors realized that there is a special problem due to sparsity on biological data which could be handled using first another normalization to improve the stability and success of the canonical correlation methodology. The method to perform the dimensional reduction using the sparse method consists on maximizing the same equation but with a different constraint: Specifically, RGCCA with all $\tau_j = 1$, combined with an L1-penalty that gives rise to SGCCA:

$$\underset{a_1, a_2, \dots, a_J}{\text{maximize}} \sum_{j,k=1}^J c_{jk} g(\text{cov}(X_j a_j, X_k a_k)) \quad \text{s.t. } \|a_j\|_2 = 1 \text{ and } \|a_j\|_1 \leq s_j, j = 1, \dots, J$$

The s_j controls the sparsity estimated of the data, the smaller it is, the higher the sparsity of X_j is. As s_j is closer to 0, more features are selected as it looks to optimize covariance; while if it is closer to 1, less features are selected and the function resembles the correlation. The values of s_j were estimated using the Schäfer method [170] when the block included 16S data or RNAseq, otherwise 1 was used.

As previously mentioned, there are different g functions that could be used; but the centroid method was chosen to detect both positive and negative relationships.

Categorical data was encoded as binary (dummy) variables for each factor except one to keep degrees of freedom, where 0 indicates not present and 1 indicates present. One level was omitted to avoid overfitting the data. Each block, regardless if it had continuous numeric variables or dummy variables was standardized to zero mean and unit variance. Later, it was divided by the square root of the number of variables of the block for an unbiased estimation.

3.4.2 Output

RGCCA as other dimensional reduction techniques provides specific weights for each variable on each dimension and a sample score on each dimension, together with quality scores.

To measure the quality of the model, the implementation provides indicators based on the Average Variance Explained (AVE). RGCCA returns an AVE score for each block, which measures how the variables of the block correlate with the dimension component of the block. It also provides two AVE scores of the whole model: the inner, which measures how each dimension accounts for the variance, and the outer, which measures how variables correlate with the dimension components. The closer the inner AVE is to 1, the better the model

adjusts to the data. However, that mathematically fits better to the data does not guarantee that the model provides more insights into the biology.

It can also generate results as other related methods based on the maximization of a function of correlations: SUMCOR (sum of correlations method) [171], SSQCOR (sum of squared correlations method) [172], SABSCOR (sum of absolute values of the correlations method) [173]. Others methods are based on the maximization of a function of covariances: SUMCOV (sum of covariances method), SSQCOV (sum of squared covariances method), SABSCOV (sum of absolute values of the covariances method). The following table summarizes the equivalent parameters needed on RGCCA to work:

Table 3.6: Equivalences of RGCCA for multi-block data analysis to other methods

Method	Scheme	Normalization	Shrinkage
SUMCOR	Horst	$Var(X_j a_j) = 1$	0
SSQCOR	Factorial	$Var(X_j a_j) = 1$	0
SABSCOR	Centroid	$Var(X_j a_j) = 1$	0
SUMCOV	Horst	$\ a_j\ = 1$	1
SSQCOV	Factorial	$\ a_j\ = 1$	1
SABSCOV	Centroid	$\ a_j\ = 1$	1

There are other methods that can be performed with RGCCA, for example: The classical canonical correlation analysis would be equivalent to data variance equal to 1 and shrinkage of 0. Partial least squares (PLS) regression, which maximizes covariance, would be equal to data variance of 1 and shrinkage of 1 in RGCCA. Finally, redundancy analysis could be performed where one block's weight normalized value is 1 and the variance of the other equals to 1.

3.4.3 Models

There is no formal definition of what constitutes a block of data on multi-omics tools. Most multi-omics and integration tools assume one block for each type of data, such as an essay a survey or an experiment. We decided to split the block with the variables about the samples to separate independent variables. The hypothesis we made was that more blocks with highly related variables but independent from the other blocks would fit better the data and thus help to identify causal or dependent variables.

To model what might be the relationships within datasets current practices include using a pre-selected model of relations between blocks. However, this model might not be an accurate representation of the relations between blocks and several models might need to be fitted. To help find the fitting model for the data I created an R package, named [inteRmodel](#), which helps finding the right model to the data via a bootstrapping procedure.

This method was applied to the previously described datasets to find the relationship between microorganisms and the disease. Following this method; to

provide a ground truth, a model with only the relationships between the two experimental obtained data is analyzed, on what it is called the model 0. The next models analyzed consisted on relationships between the two experimental blocks and a block with all the metadata of the samples. These models are denoted by 1.Y, where 1 denotes the family 1 and Y is used to label some of the models of this family.

Later instead of a big metadata block, following our theory we split this metadata block on several ones, having a block for time related variables, another one for location and the other about the people on the study. This allows to design a model with an expected relationships between these blocks and makes more interpretable the relationships. These models are from the family 2 denoted by the name 2.Y, where 2 denotes the family of the model and Y change for particular models with different relationships between the blocks change.

For each family of models we tested all possible relationships with weights between 0 and 1 by 0.1 intervals to find the best model on each datasets according to the AVE score.

The final models were further validated using a bootstrap approach to measure their accuracy and likelihood on the data available.

3.5 Statistics

Differential expression analysis was performed with the limma-trend method [174, 175] and edgeR [145] (Bioconductor version 3.10 or superior) packages. Data was normalized using the trimmed mean of M-values and log-2 transformed into counts per millions following the workflow previously described using voom [176].

To correct for multiple testing, the false discovery rate was estimated using the method of Benjamini and Hochberg [177]. A gene was considered differentially expressed when it was significant at 5% FDR. Special attention was given to those genes that showed a fold-change higher than |1.5|.

3.6 Functional enrichment methods

Functional enrichment methods are those methods that aim to provide with more information about the variables besides their numerical value measured. They can be very different in nature but they all use the numeric values of the variables and other information, being it from the same experiment data collection or from external data sources.

Many functional enrichment methods are based on an over representation analysis, where a group of elements is tested for their mesure in other groups. This can be done with `clusterProfiler` which tests genes enrichment for functionality based on information on pathway databases [178] that it is used in several publications [179]. `clusterProfiler` checks the enrichment of features of a given group on the (background) list provided.

$$\begin{aligned} H_0 : P_{\text{subset}} &\leq P_{\text{overall}} \\ H_1 : P_{\text{subset}} &> P_{\text{overall}} \end{aligned}$$

The statistical test used is usually the fisher test, the hypergeometric test or the proportion test. I describe the hypergeometric test and the proportion test below.

3.6.1 Fisher test

The fisher test calculates how independently are two categories. Say if genes in category X are independent of category Y, if we use the contingency table

Table 3.7: Fisher contingency table

	In category X	Not in category X	Row total
In category Y	a	b	a+b
Not in category Y	c	d	c+d
Column total	a+c	b+d	a+b+c+d = n

Given this contingency table 3.7, the probability of X and Y being independent can be calculated with:

$$\begin{aligned} P &= \frac{\binom{a+b}{a} \binom{c+d}{c}}{\binom{n}{a+c}} \\ &= \frac{(a+b)! (c+d)! (a+c)! (b+d)!}{a! b! c! d! n!} \end{aligned}$$

3.6.2 Hypergeometric test

The hypergeometric distribution describes the probability of k successes (when the object drawn has a specified feature) in n draws², from a finite population of size N that contains exactly K objects with that feature, wherein each draw is either a success or a failure.

In this context N is the number of genes being used and n the number of genes on a pathway. It can be used to compare the genes found on a pathway (k genes) compared to the expected K numbers of the distribution using the following equation:

$$P_X(k) = P(X = k) = \frac{\binom{K}{k} \binom{N-K}{n-k}}{\binom{N}{n}}$$

²without replacement

This looks like the fisher test, because hypergeometric test assesses the extremeness of observing k or more of that overlap (a on b) and thus it is the same as a one-sided Fisher's exact test.

3.6.3 Proportion test

The overrepresentation of a given group of elements can also be tested with the proportion test, which is sometimes also used on clusterProfiler. The proportion test uses the χ^2 distribution to test if the observed frequency (O_i) is close to the expected frequency (E_i):

$$\chi^2 = \sum_{i=1}^n \frac{(O_i - E_i)^2}{E_i} \simeq \chi^2_{n-p}$$

As this is usually done on a 2x2 contingency table it is equivalent to the Z-test of proportion. Sometimes, the expected frequency is so low that a correction must be done to the estimation:

$$\chi^2_{\text{Yates}} = \sum_{i=1}^n \frac{(|O_i - E_i| - 0.5)^2}{E_i}$$

This increases the p -value as it raises the Chi-square statistic.

3.6.4 Gene Set Enrichment Analysis

There are other methods that test if some variables show an unexpected importance according to a statistic like fold change or value, such as gene set enrichment analysis (GSEA) [180]. GSEA is a computational method originally developed to determine whether a priori defined set of genes shows statistically significant and concordant differences between two biological states. This methods check if a group of variables present in an ordered list shows a skewed distribution and it compares it against a random group of similar size. It has been widely used since its original publication, also on IBD [181].

This method calculates the rank of genes $rank(g_j) = r_j$ where each g is a gene, and then it calculates the following functions:

$$P_{hit}(S, i) = \sum_{g_j \in S, j \leq i} \frac{|r_j|^p}{N_R}, \text{ where } N_R = \sum_{g_j \in S} |r_j|^p$$

$$P_{miss}(S, i) = \sum_{g_j \notin S, j \leq i} \frac{1}{N - N_H}$$

With these values the enrichment score (ES) defined as: $ES = max(|P_{hit}(S, i) - P_{miss}(S, i)|)$ is calculated from the walk. At least 1000 permutations are usually used but a high number of permutations are required for an accurate estimation of the enrichment score. However, when more than one pathway (S) is evaluated

in order to compare between their enrichment scores, they must be normalized by dividing the scores by the mean of all the ES. When power p is 0 it is equivalent to the standard Kolmogorov–Smirnov statistic, though it is usually set to 1.

For testing GSEA I used [fgsea](#) [182] implementation for its speed and integration with other methods used in this thesis. Gene pathways from the RE-ACTOME database were tested on the weight of different models or on the comparisons performed [183].

3.6.5 GSVA

To estimate the expression of the pathways and compare their expression levels between conditions gene set variation analysis as implemented on [GSVA](#) was used [184]. It is a method that summarizes the variables' numerical value changing the space of variable x sample to group x sample. This enables other methods to use this new space instead of the original variables, which provides a successful way to look into data [185]. GSVA was used (again from the RE-ACTOME database) to find the relationships between the pathways and the microbiome at different taxonomic levels.

This is done via an estimation and a comparison with a discrete Poisson kernel: i indicates the gene from a total of k genes, and samples are indicated by j from n number of samples.

$$z_{ij} = \hat{F}_r(x_{ij}) = \frac{1}{n} \sum_{k=1}^n \sum_{y=0}^{x_{ij}} \frac{e^{-(x_{ik}+r)}(x_{ik}+r)^y}{y!}$$

$r = 0.5$ is used to set the mode of the Poisson kernel at each x_{ik} , that is, similar to the expression of a gene for a given sample.

Later this is converted to ranks $z_{(i)j}$ for each sample and normalized: $r_{ij} = |\frac{p}{2} - z_{(i)j}|$ to make the distribution of ranks symmetric around zero to later compare with a normal distribution using a Kolmogorov-Smirnov-like random walk statistic:

$$v_{jk}(l) = \frac{\sum_{i=1}^l |r_{ij}|^\tau I(g_{(i)} \in \gamma_k)}{\sum_{i=1}^p |r_{ij}|^\tau I(g_{(i)} \in \gamma_k)} - \frac{\sum_{i=1}^l I(g_{(i)} \notin \gamma_k)}{p - |\gamma_k|}$$

Here τ describes the weight of the tail in the random walk (default is set to 1). γ_k is the k-th gene set and $I(g_{(i)} \in \gamma_k)$ is the indicator function whether the gene ranked i-th belongs to the gene set γ_k . $|\gamma_k|$ indicates the ordination of the gene set, the number of genes of the gene set and p the number of genes in the dataset.

This difference is later converted to enrichment score for each gene set for each sample, similar to GSEA. This score can be calculated as a difference of hits and misses or the maximum deviation from zero of the random walk (which allows to detect gene sets that have genes with different opposing expression patterns).

3.7 Variance and diversity methods

3.7.1 PERMANOVA

The PERMANOVA method [186, 187], provided by the `vegan` package on the `adonis` function, was used to test if microbiome data variance is due to other variables when using distances metrics. It uses the residual sum of squares such as:

$$SS_W = \frac{1}{n} \sum_{i=1}^{N-1} \sum_{j=i+1}^N d_{ij}^2 \epsilon_{ij}$$

When using euclidian distances (d) it is equivalent to MANOVA. Here ϵ_{ij} takes the value of 1 if the observation i and the observation j are in the same group, otherwise it takes the value of 0. This can be later used to test which variance is bigger, inter-groups or intra-groups by using the following formula:

$$F = \frac{SS_A/(\alpha - 1)}{SS_W/(N - \alpha)}$$

Where SS_A is the among group sum of squares, representing the intra-group variance. N is the number of samples and α the number of different groups.

This allows to test if the variables are related to the variance of the data as it can be compared with the F statistic after a high number of permutations.

3.7.2 globaltest

It is a method for testing complex hypothesis and calculate the influence of each variable on a given outcome [188]. I tested which variables, (sex, age, location, time since diagnosis, treatment) are important on the datasets with `globaltest` (Version 5.40 or later). This method provides a general statistic to test hypothesis against a high dimensional dataset.

$$S = \sum_{i=1}^p x_i' x_i g(t_i^2)$$

The global test performs a test statistic on the transformed t-test, where if p , the number of variables, is large the test is more powerful on average over all possible sparse alternatives of general functions g .

It was performed with variables individually and also with interactions between the different variables.

3.7.3 Diversity indices

Microbiome diversity was measured using vegan and [phyloseq](#) methods [189]. α -diversity is a measure of how much a given microbiome at a taxonomic level is present on a sample. Several measures exists, on the thesis I used the effective Simpson or effective Shannon diversity index to compare diversity between samples and conditions. β -diversity was calculated using the phyloseq package for exploratory analysis.

The effective Simpson (also known as inverse Simpson) and the effective Shannon are:

$$D_{\text{effective Simpson}} = \frac{1}{\sum_{i=1}^S p_i^2}$$

$$D_{\text{effective Shannon}} = \frac{1}{-\sum_{i=1}^S p_i \log_e p_i}$$

Where p_i is the proportion of species i and S is the number of species.

3.8 Other methods

3.8.1 WGCNA

To look for relationships between the microbiome and the RNAseq we used weighted gene co-expression network analysis. We used weighted gene co-expression network analysis as implemented on [WGCNA](#) [190] as well as correlations. The Spearman rank correlation coefficient is:

$$R_s(X, Y) = \frac{\sum_{i=1}^n (R_i - \bar{R})(S_i - \bar{S})}{\sqrt{\sum_{i=1}^n (R_i - \bar{R})^2} \sqrt{\sum_{i=1}^n (S_i - \bar{S})^2}}$$

Being $(X_1, Y_1), \dots, (X_n, Y_n)$, assign a rank where $(R_1, S_1), \dots, (R_n, S_n)$ for n being all the variables where $\bar{R} = \frac{1}{n} \sum_{i=1}^n R_i$ and likewise $\bar{S} = \frac{1}{n} \sum_{i=1}^n S_i$. The distribution of the Spearman correlation coefficient is symmetric around 0 and can be approximated to a normal distribution as $\sqrt{n-1}R_s(X, Y) \sim N(0, 1)$ which can be used to calculate the p-value of a given estimation.

3.8.2 BaseSet

[BaseSet](#) was developed and used to find which variables are really involved on the interaction and how likely they were to be together. It is a package that uses fuzzy set logic to calculate the probability to belong to a group, in this case, those genes and bacteria selected by the model that interact with the other.

Under the standard fuzzy set logic a set S is a group of elements for which each element e has an α membership to that set [191, 192]. α is usually bounded

between 0 and 1: $\alpha \in [0, 1]$. A given element e can belong to more than one set. Assimilating the membership function to probability we can calculate the probability of a given element e to belong to a set S and not any other set: $P(e \in S | e \notin S^c)$. Which applied to the data and the case at hand, it is the probability that a given variable is associated with a given outcome and not with any other outcome.

The membership function was derived from the bootstraps used for each model on the thousand iterations of the integrative method applied to give an estimation of how probable is a given gene and bacteria to be selected as relevant for the model. The bootstraps of the models were used to calculate the probability of a variable to be selected by RGCCA. This probability was used to calculate (via `set_size`) the genes and bacteria that are specific of the model that allows to separate the transcriptome by its location and the microbiome by the disease status.

3.8.3 experDesign

`experDesign` was developed [193] to prevent and quantify if a given experiment has batch effect due to the batches used to measure the values or other known variable. It might help to detect a bad design of the experiment.

On pseudo code the core of the program can be described as:

```

for each index:

    for each batch

        pick size(batch) samples

        if samples are in another batch

            pick other samples

    for each batch

        calculate some summary statistics

        compare with the summary statistics of all the samples

    keep the index with less differences between the index and all the samples

```

Summary statistics taken into account are the median, the variance, the range, the number of missing values, and the entropy of the categorical variables. It can take into account spatial distribution and, given the number of samples that fit on a batch, provide which technical replicates³ are best to use.

³Technical replicates are samples that are measured multiple times to ensure the accuracy of the measurement. In contrast biological replicates are sample with the same conditions but different individuals or process before the measurement.

3.8.4 ROC- AUC

To estimate if the selected features (genes or microorganism) by the integration methods have some biological meaningful contribution I measured if they can classify features, such as, which gastrointestinal segment is each sample from, or which type of disease does each patient have.

To compare between different models the area under the curve (AUC) of the receiver operating characteristic (ROC) was calculated with the [pROC](#) package [194]. It is based on the following formulas, where FP is false positive, N is a negative, P is positive, TP is true positive and FN is false negative:

$$FPR = \frac{FP}{N} = \frac{FP}{FP + TN}$$

$$TPR = \frac{TP}{P} = \frac{FP}{FP + FN}$$

The ROC curve is that where the true positive rate (TPR) or sensitivity, recall or hit rate is represented against the false positive rate (FPR) on the abscissa. The area under this curve is a measure of how good such classifications performs overall, being 0.5 as good as a random selection. The closer it is to 1 the better as it classifies incorrectly less samples and accurately classify more.

Chapter 4

Results

4.1 Packages/methods

4.1.1 experDesign

`experDesign` package built in R was released for the first time on CRAN on 2020-09-08 after nearly a year after the initial release made on [github](#). It was published on a journal on 2021-11-27 [193].

The package uses functional programming to create and modify objects and the features used. The package bases its performance on the large body of work made by the R core team. It adds the information to the introduced `data.frame` or returns an vector with the appropriate information.

`experDesign` functions are divided into several categories:

- Helper functions to aid on deciding how many batches are or how many samples per batch. There are some also that report how good a given distribution of the samples felt for a given dataset.
- Functions generating indexes.
- Functions distributing the samples on indexes

Regarding time related variables `experDesign` will use them as factors, while issuing a warning to the user.

Since its development it has been used on a couple of RNA sequencing experiments that required a batch design, one of organoids bulk RNA-seq and another one of biopsies bulk RNA-seq from the BARCELONA cohort. It was also used to check if there is any observable batch effect on the datasets analyzed.

On the designed datasets `experDesign` worked well and no batch effect was created when sequencing the samples. However, on the organoids dataset, a change on the matrigel used to produce them introduced a batch effect that

made it impossible to compare samples before and after that change (there were not any shared sample before and after the change of matrigel).

Since its release on CRAN it has had a median of ~400 downloads each month from RStudio repository mirror. Showing the interest the community have on solutions like this.

4.1.2 BaseSet

`BaseSet` package, built in R, was released for the first time on CRAN on 2020-11-11, nearly two years after the initial work started on [github](#).

The package uses both functional programming and object oriented program to create and modify the TidySet S4 object defined¹. Mixing it with S3 generic functions it provides a powerful interface compatible with the tidyverse principles, a [group of packages](#) following the same design. The package provides a new class to handle fuzzy sets and the associate information.

`BaseSet` methods are divided into several categories:

- [General functions](#) to create sets of the TidySet class or convert from it to a list or about the package.
- [Set operations](#) like adjacency cartesian product, cardinality, complement, incidence, independence, intersection, union, subtract, power set or size.
- [Functions to work with TidySets](#) to add relationships, sets, elements or some complimentary data about them. Remove the same or simply move around data or calculate the number of elements, relations and sets.
- [Functions to read](#) files from formats where sets are usually stored in the bioinformatician field: GAF, GMT and OBO formats.
- Last, some [utility functions](#) to use set name conventions and some other auxiliary functions.

The package had a long development process with initial iterations basing on `GSEABase` package which was later abandoned ([GSEAdv](#)) to also include some uncertainty on the relationship of a gene with a given gene set.

The package also participated on an exploration on part of the Bioconductor community (project to develop, support, and disseminate free open source software that facilitates rigorous and reproducible analysis of data from current and emerging biological assay) for more modern and faster handling of sets. There were three different packages created as part of this process, `BaseSet`, `BiocSet` published [on Bioconductor](#) and `unisets`, available [on github](#). The three different approaches were presented at a birds of feather on BioC2019.

The package passed the review on the rOpenSci organization ([See review](#)) and is now part of the packages hosted there too.

Since its release on CRAN it has had a median of ~400 downloads each month from RStudio package manager.

¹S4 is one of the object programming paradigms on R. For a more complete overview and differences see [Advanced R \[195\]](#).

4.1.3 inteRmodels

The package was build once the method used to find accurate models of the relationships of the data available of a dataset using RGCCA was established. Using the package [on github](#) simplifies the process and makes it easier to redo it .

The package has functions that can be grouped in three categories:

- To look for models and evaluate them. There are functions to search for a model given some rules, that check them using leave-one-out methodology.
- Reporting: To make better reports by improving handling of names or simplifying the objects or how to calculate scores.
- Building: To easier build correct models on RGCCA, simplifying the process to create a symmetric matrix.

Currently it is only [available on github](#), so the number of downloads and usage is unknown but since its release a user has contacted to keep it up to date with development versions of RGCCA. Currently, it is compatible with the next release of [RGCCA being prepared](#)².

To search models it starts with a initial connectivity of the blocks and creates all the combinations of connections given .

The functions `analyze` helps to analyze code of a single integration, providing the results on a tidy format for further processing. To create the connections between blocks the function `weight_design` is available. It creates all the possible matrices given a number of blocks and a number of weights. Optionally it can create just a subset of those based on a numeric vector. However, it does not provide a way to have the design named.

If the user wants to create their own design matrices, they can use `symm` and modify the design of the model with `sbuSymm`. `symm`, takes an initial matrix to pick up the row and column names. It is recommended that the user checks the design matrix is fully connected, which the package facilitates with the function `correct`. This is also recommended even if the design matrices are created with `weight_design`.

For the bootstrap procedure there is the function `boot_index` to create the bootstrapped index of samples to be used by `boot_index_sgcca`. If the bootstrapped samples used is not important one can use `boot_samples_sgcca`. If the users want to perform a leave-one-out procedure they can use `looIndex`.

The package cannot choose which variables use from the block with information to split into several blocks. However, it provides the `model_RGCCA` function to make it easy to prepare such variables for RGCCA input. The `inteRmodel` procedure will only be useful if the user should decide which variables are independent from others and split them into different blocks. To asses this the user can use the methods we used, as described on the above section 3.7. It is important to keep in mind the possible causal relationships on user's data [196].

²I also contributed with some comments and feedback to the package to make it easier to read the source and check the inputs and improve the documentation so that it is coherent with the code and previous results of the functions.

4.2 Analysis

On the following sections the main results of analyzing each dataset are presented.

4.2.1 Puget's dataset

On this dataset the different parameters and capabilities of RGCCA were tested.

The three different methods, centroid, factorial or horst were tested and compared. The main result of this comparison was that the differences of the selection of the variables mattered more than the number of variables selected with each method. The models were tested with different weights on all three schemes: horst, centroid and factorial. The horst and the centroid scheme were similar while the factorial resulted in the most different AVE values (see [S1 Data](#) of [197]). The centroid scheme was selected because it takes into account all the relationship regardless of the canonical correlation sign between the blocks and it is similarity to horst scheme.

The effect of the sparsity value was measured by its effect on the inner AVE scores and the combination of the different values for each block.

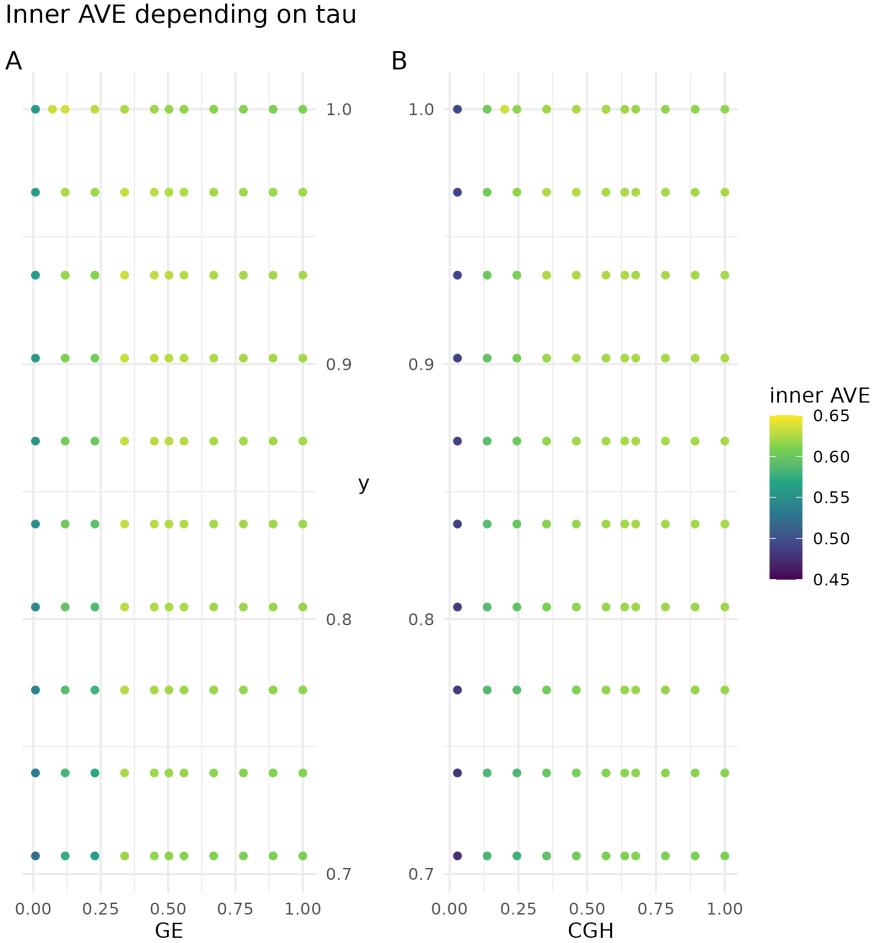


Figure 4.1: Effect of tau on the inner AVE on Puget's dataset. The suggested tau value is the column between the regular grid, on the ordinate axis the y's tau values and on the abscissa the gene expression (GE) on the left and the comparative genomic hybridization (CGH) on the right. The highest inner AVE is with high tau values for y and middle to upper values for GE and CGH.

Table 4.1: Relationships between the different blocks on the Puget dataset for model 1. 0 indicates no relationship and 1 indicates a strong relationship.

Model 1	GE	CGH	Localization
GE	0	0	1
CGH	0	0	1
Localization	1	1	0

When looking for the model that adjust better following this structure we arrived

to model 1.2, described below:

Table 4.2: Relationships between the different blocks on the Puget's dataset for model 1.2. 0 indicates no relationship and 1 indicates a strong relationship.

Model 1.2	GE	CGH	Localization
GE	0	0	1
CGH	0	0	0.1
Localization	1	0.1	0

On model two we split the invariable variables from those related to the location:

Table 4.3: Relationships between the different blocks on the Puget's dataset for model 2. 0 indicates no relationship and 1 indicates a strong relationship.

Model 2	GE	CGH	Invariable	Localization
GE	0	1	1	1
CGH	1	0	1	1
Invariable	1	1	0	0
Localization	1	1	0	0

Following this split, the model that has higher inner AVE for these blocks is the following:

Table 4.4: Relationships between the different blocks on the Puget's dataset for model 2.2. 0 indicates no relationship and 1 indicates a strong relationship.

Model 2.2	GE	CGH	Invariable	Localization
GE	1	1/3	0	1
CGH	1/3	0	1/3	0
Invariable	0	1/3	0	0
Localization	1	0	0	0

If we added a superblock with all the data of the different blocks from model 1 we started with the standard relationship between blocks:

Table 4.5: Relationships between the different blocks on the Puget's dataset for model superblock. 0 indicates no relationship and 1 indicates a strong relationship.

Model superblock	GE	CGH	Superblock	Localization
GE	0	0	1	0
CGH	0	0	1	0
Superblock	1	1	0	1
Localization	0	0	1	0

But when the best model with the superblock that had highest inner AVE is quite different:

Table 4.6: Relationships between the different blocks on the Puget's dataset for model superblock.2. 0 indicates no relationship and 1 indicates a strong relationship.

Model superblock.2	GE	CGH	Superblock	Localization
GE	1	1/3	0	1
CGH	1/3	0	1	0
Superblock	0	1	0	0
Localization	1	0	0	0

Exploratory analysis with the superblock model was done. The first two components of the superblock did not help to explain the biology or classify the tumors:

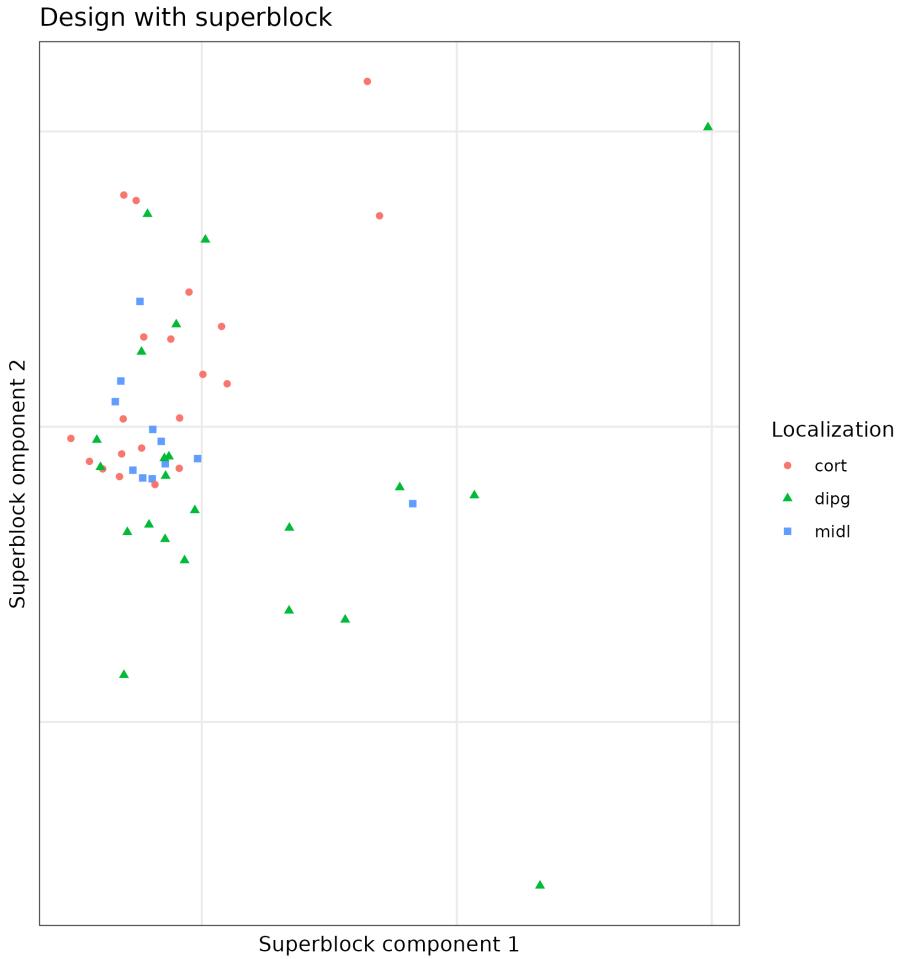


Figure 4.2: First components of the superblock which has all the data of the samples on the Puget's dataset.

The same data was used to look for a good model from the data itself including a model with a superblock but looking at the first component of the CGH and transcriptome block. This allowed to visually inspect if each model's components helped to classify the samples:

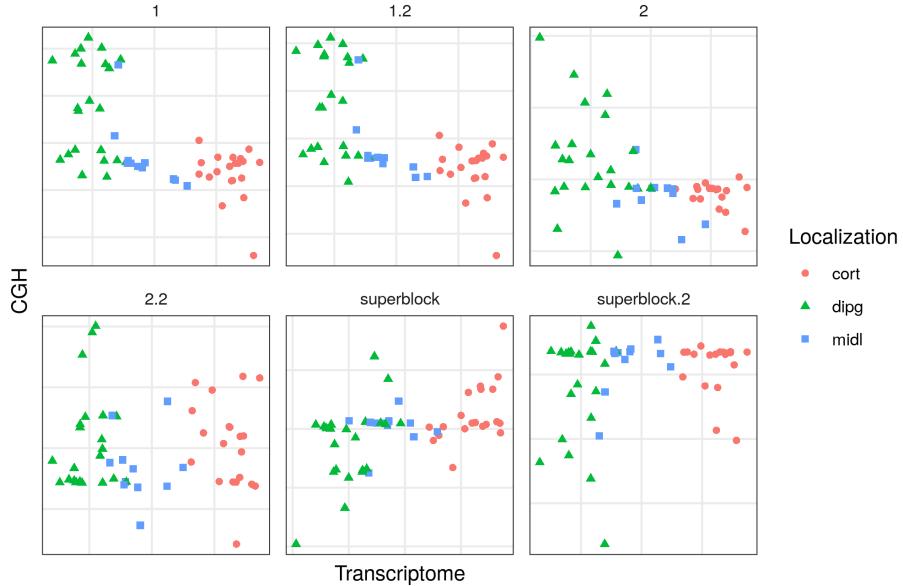


Figure 4.3: Different models tried with the same data showing the first components of the CGH data and the transcriptome. Model 1 and 1.2 with transcriptomics, CGH data and all the data about the samples together. Model 2 and 2.2 with transcriptomics, CGH data and all the data bout the samples on different blocks. Model superblock and superblock.2 have all the data in different blokcs and one block with all the data.

Showing the components of the CGH and the transcriptomics of the superblock show better classification than that of the superblock. However the other models show a better classification of the samples with much simpler models.

To find these models the three blocks with the best tau and the centroid scheme were analyzed by changing the weights between 0 and 1 by 0.1 intervals. According to the inner AVE, the best model was the one in which the weights (1) between the host transcriptome and location, (2) the host transcriptome and the CGH, and (3) the CGH block were linked to variables related to the location with weights of 1, 0.1 and 0.1, respectively.

When we added a superblock to the data, there was a slight increase of 0.01 on the inner AVE of the model. The model with the superblock that explained most of the variance was that in which the weights of the interaction within (1) the host transcriptome, (2) between the superblock and the CGH, (3) between the host transcriptome and the localization, and (4) between CGH and the host transcriptome were 1, 1, 1 and 1/3, respectively. To see if the superblock could classify the sample by location, we plotted the first two components of the superblock.

We can clearly see that they do not classify the samples according to the location of the tumor, which is known to affect the tumor phenotype [149].

Adding one block containing the age of the patient and the severity of the tumor to the model, decreased the inner AVE. The best model with these blocks, according to the inner AVE, was that in which the interactions (1) within the host transcriptome, (2) between the host transcriptome and the localization, (3) between the host transcriptome and(4) the CGH and between the CGH and the other variables were 1, 1, 1/3 and 1/3, respectively. The first components of each model can be seen in the figure:

We can observe on the figure 4.3, the strong dependency between gene expression and location since the first model while the weaker relationship with the CGH assay [149]. On the other hand, the major difference is the dispersion on the CGH component on each model.

The effect of the superblock and weights on different models to the inner AVE. There are significant differences between having the superblock and not having it.

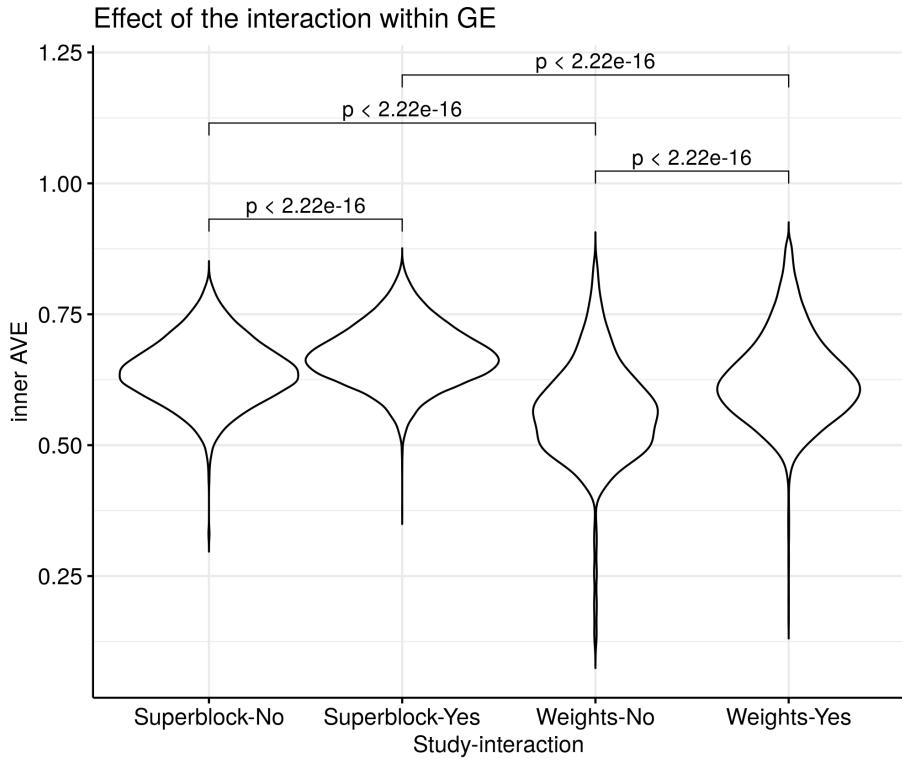


Figure 4.4: Effect of superblock and weights on the inner AVE on Puget's dataset. Designs with the superblock showed higher inner AVE scores than without it. Interaction yes/no indicates RNA and CGH interaction.

The different models resulted on the following AVE values.

Table 4.7: The models and their AVE values.

Model	inner AVE	outer AVE
1	0.6333592	0.06920968
1.2	0.851236	0.06923187
2	0.2791546	0.07386952
2.2	0.6902329	0.06927069
superblock	0.7055847	0.07345775
superblock.2	0.8047477	0.06958205

4.2.2 HSCT dataset

The permanova analysis was performed on this dataset to estimate which were the variables that are more relevant. From the many variables the location, sex, patient id and others were found to be related to the variability of the microbiome or the transcriptome on this dataset.

With the permanova analysis we found that more than 50% of the variance of normalized RNA-seq data and microbiome data respectively is explained by the variables of location, disease, sex, and the interaction between disease and sex. On the transcriptome the most important factor is location which is more than 15% of the variance, while on the microbiome data the most important factor is the patient id followed by location of the sample.

```
> all_RNA

Call:
adonis(formula = as.data.frame(t(expr))[-pos, ] ~ Exact_location *      IBD * SEX, data = m
euclidean")

Permutation: free
Number of permutations: 5000

Terms added sequentially (first to last)

      Df SumsOfSqs MeanSqs F.Model      R2 Pr(>F)
Exact_location      5   1283547  256709  6.8734 0.18057 0.00020 ***
IBD                 1    221808  221808  5.9389 0.03120 0.00020 ***
SEX                 1     92850   92850  2.4860 0.01306 0.00120 **
Exact_location:IBD  2    90931   45466  1.2173 0.01279 0.11798
Exact_location:SEX  4    172507  43127  1.1547 0.02427 0.11458
IBD:SEX              1    58024   58024  1.5536 0.00816 0.03519 *
Exact_location:IBD:SEX 1    34557   34557  0.9253 0.00486 0.52190
Residuals            138  5154088  37348           0.72508
Total                153  7108313               1.00000
---
Signif. codes:  0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1

> all_16S

Call:
adonis(formula = as.data.frame(t(otus_table_i))[-pos, ] ~ Exact_location *      IBD * SEX, i
thod = "euclidean",      by = "margin")

Permutation: free
Number of permutations: 5000

Terms added sequentially (first to last)

      Df SumsOfSqs MeanSqs F.Model      R2 Pr(>F)
Exact_location      5    24615   4923.0  2.0238 0.06061 0.0002000 ***
IBD                 1    20175   20174.7  8.2938 0.04967 0.0002000 ***
SEX                 1     6952   6952.0  2.8580 0.01712 0.0003999 ***
Exact_location:IBD  2    4431    2215.7  0.9109 0.01091 0.6604679
Exact_location:SEX  4    8485   2121.4  0.8721 0.02089 0.8476305
IBD:SEX              1    4626   4626.3  1.9019 0.01139 0.0075985 **
Exact_location:IBD:SEX 1    1175   1174.8  0.4830 0.00289 0.9994001
Residuals            138  335683  2432.5           0.82652
Total                153  406143               1.00000
---
Signif. codes:  0 '***' 0.001 '**' 0.01 '*' 0.05 '.' 0.1 ' ' 1
```

With globaltest the results were similar. The resulting p-value was well below the 0,05 threshold defined for RNA-seq data on the models including the segment of the sample, sex and treatment.

```
> gt(SESCD_local~SEX+IBD+Exact_location+AGE_SAMPLE+diagTime, rna)
  p-value Statistic Expected Std.dev #Cov
1 5.7e-21      4.18    0.694   0.104 37662
```

On the microbiome data the results were similar but the p-value was considerably higher but still below the threshold.

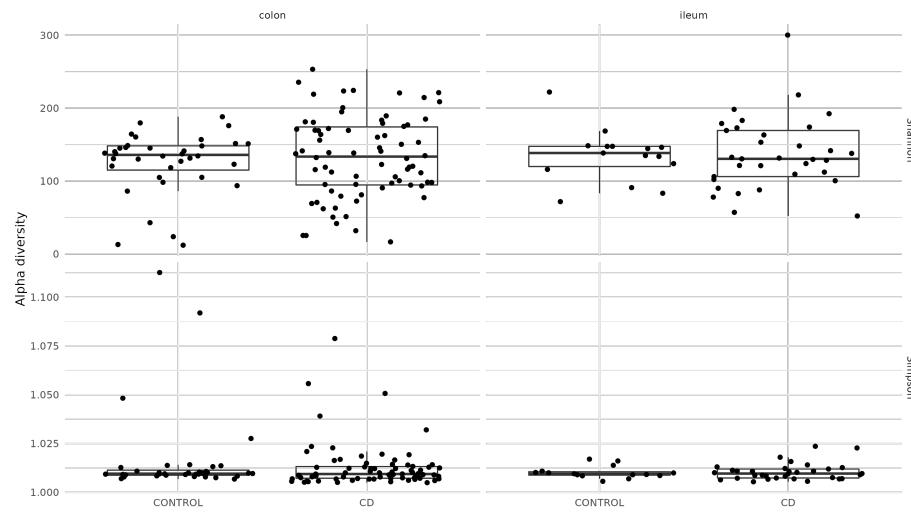


Figure 4.5: Microbiome diversity on HSCT dataset. On the upper section the Shannon effective and on the lower row the Simpson effective diversity splitted by colon and ileum and controls and CD.

Diversity indices of the samples were explored and compared for several subsets. Splitting by location of the sample and disease provided the highest differences and the diversity index along time did not change much.

Weighted gene co-expression network analysis did not provide relevant links between bacteria and transcriptome as it failed to find an acceptable scale free degree.

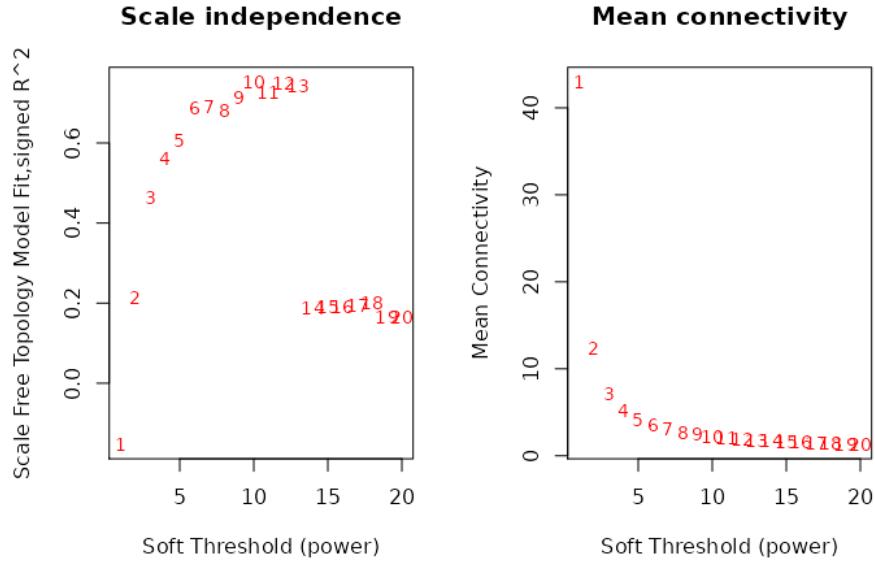


Figure 4.6: Power evaluation of WGCNA of the HSCT dataset. On the ordinate the power on the abscissa on the left the scale free topology model fit; on the right the mean connectivity. There is a low fit even on large power and the mean connectivity is below 100 from the very first value.

As can be seen on the Figure 4.6, the scale free topology does not reach the recommended threshold of 0.9 and the mean connectivity is also very low even for the first power.

STATegRa was used between stool 16S data and intestinal 16S data under the assumption that there is a shared common factor without influence of other categorical variables. However, it did not find a good agreement between these two data sources and 16S data source was not longer used on the analysis. In addition, the model is fixed, so it did not allow to find new or other relationships that are not one to one.

With RGCCA we could select different models and use all the data available without much assumptions. The models with the highest inner AVE of the family 1 and the family 2 models were similar to those on the Häslar dataset.

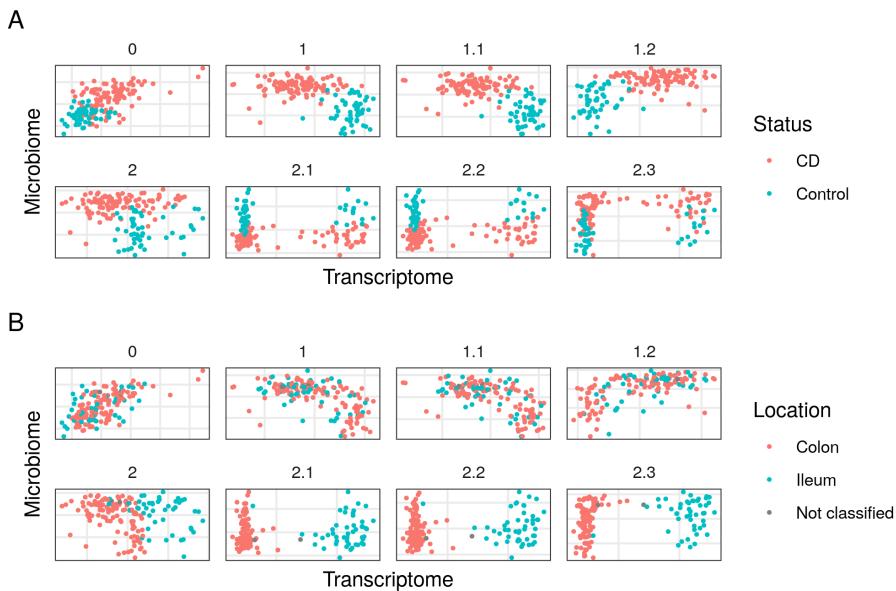


Figure 4.7: On the abscissa the transcriptome, on the ordinate the Microbiome. Each square represents a different model of the HSCT dataset. On panel A colored by disease status, on panel B colored by sample location. Model 0 has only transcriptome and microbiome data, models 1 to 1.2 with data about the samples and models 2.1 to 2.3 with data about the samples split in 3 blocks.

The weights of these models can be observed here:

Table 4.8: Relationships between the different blocks on the HSCT dataset for model 0. 0 indicates no relationship and 1 indicates a strong relationship.

Model 0	Transcriptome	Microbiome
Transcriptome	0	1
Microbiome	1	0

Table 4.9: Relationships between the different blocks on the HSCT dataset for model 1. 0 indicates no relationship and 1 indicates a strong relationship.

Model 1.1	Transcriptome	Microbiome	metadata
Transcriptome	0	0	1
Microbiome	0	0	1
metadata	1	1	0

When looking for the model that adjust better following this structure we arrived to model 1.2, described below:

Table 4.10: Relationships between the different blocks on the HSCT dataset for model 1.2. 0 indicates no relationship and 1 indicates a strong relationship.

Model 1.2	Transcriptome	Microbiome	metadata
Transcriptome	0	0	1
Microbiome	0	0	0.1
metadata	1	0.1	0

On model two we split the invariable variables from those related to the location:

Table 4.11: Relationships between the different blocks on the HSCT dataset for model 2. 0 indicates no relationship and 1 indicates a strong relationship.

Model 2	Transcriptome	Microbiome	Location	Demographic	Time
Transcriptome	0	1	1	1	
Microbiome	1	0	1	1	
Demographic	1	1	0	0	
Location	1	1	0	0	

Following this split, the model that has higher inner AVE for these blocks is the following:

Table 4.12: Relationships between the different blocks on the HSCT dataset for model 2.2. 0 indicates no relationship and 1 indicates a strong relationship.

Model 2.2	Transcriptome	Microbiome	Demographic	Location	Time
Transcriptome	0	0	0	0.6	0
Microbiome	0	0	0.2	0.1	0
Demographic	0	0.2	0	0	1
Location	0.6	0.1	0	0	0
Time	0	0	1	0	0

We also tested specifically a model from the family 2.3

Table 4.13: Relationships between the different blocks on the HSCT dataset for model 2.3. 0 indicates no relationship and 1 indicates a strong relationship.

Model 2.3	Transcriptome	Microbiome	Demographic	Location	
Transcriptome	0	0	0	1	0
Microbiome	0	0	0.1	0.1	0
Demographic	0	0.1	0	0	1
Location	1	0.1	0	0	0
Time	0	0	1	0	0

The best model of the family 2 confirmed a relationship between the host transcriptome and the location-related variables, while the microbiome was associated with the demographic and location-related variables (see Figure and S2 data of [197]). Overall, we see that the relationships in the model affected the distribution of samples on the components of both the host transcriptome and the microbiome.

Table 4.14: The models on the HSCT and their AVE values.

Model	inner AVE	outer AVE
0	0.3999234	0.10016886
1	0.623019	0.08423331
1.1	0.5678189	0.08487135
1.2	0.7043881	0.07757663
2	0.2517363	0.09820497
2.1	0.6940253	0.09402657
2.2	0.818764	0.09416275
2.3	0.7761846	0.09439379

The different models selected different variables, some of which are shared between models. The most similar models are those that have split the metadata into 3 blocks, followed by those that have the metadata in a single block.

In order to analyze the accuracy of the models, one thousand bootstraps were used to integrate the data from the HSCT CD dataset. Each bootstrap had its own dispersion on the variables according to the samples selected, the distribution of the bootstraps used are represented here:

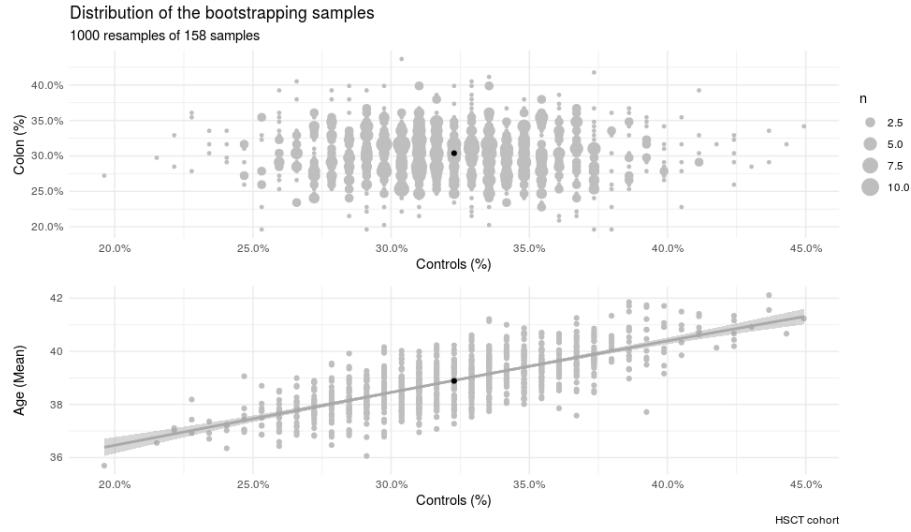


Figure 4.8: Dispersion of the bootstrapped samples on age and percentage of colon and controls samples.

Evaluating the same model on each bootstrap lead to a dispersion on the inner AVE of the model. The lower the dispersion, the more robust the model was to different conditions than in the initial testing.

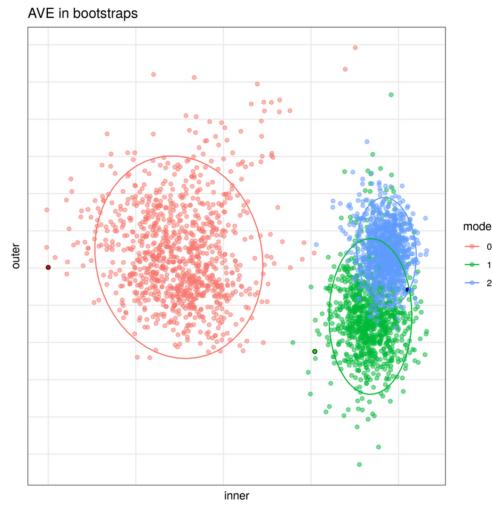


Figure 4.9: Bootstrap of the models 0, 1.2 and 2.2. The point with the black circle is the AVE of the original data. The dispersion is shown by the ellipses. Model 0 and 1.2 have lower inner and outer AVE score, model 2.2 has lower outer score but higher inner value than the bootstrapped.

With the bootstrapped models we used BaseSet to estimate the probability that

each variable to be relevant for the association with a disease. However, due to big amount of small probabilities when using the BaseSet package to calculate which variables are more relevant it could not provide a good estimation on time.

MCIA was applied as a baseline of the integration, the first two components were represented similarly to those of the blocks when using RGCCA.

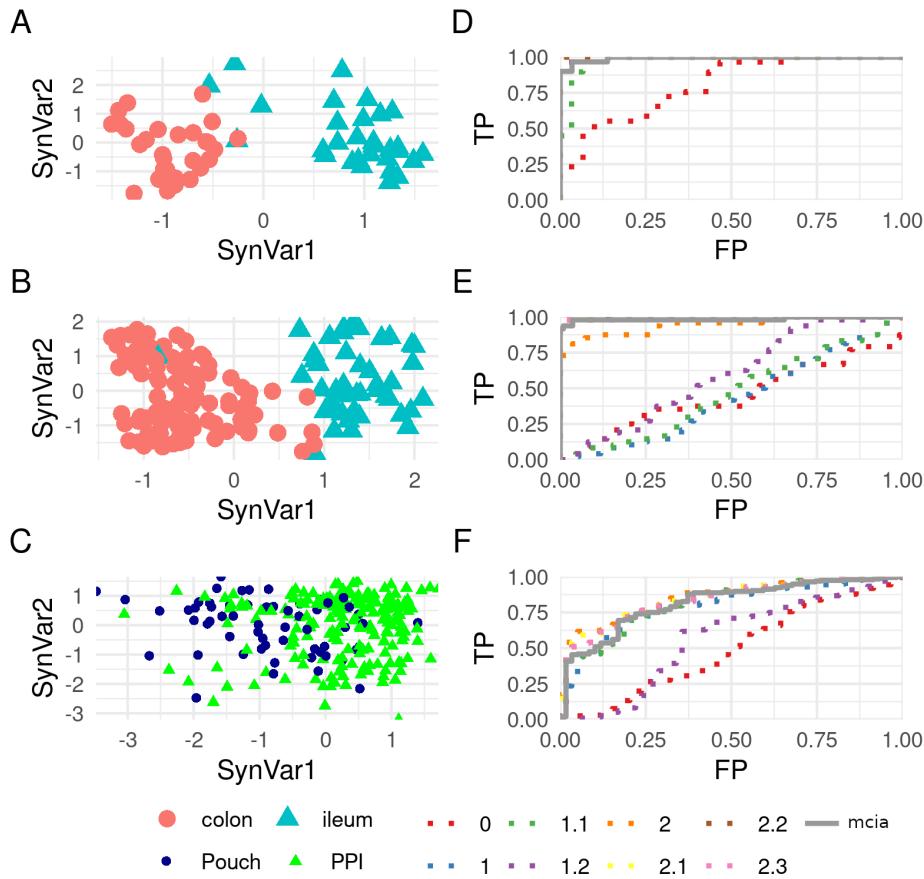


Figure 4.10: MCIA first two synthetic variables on the IBD related cohorts. In red circles the colon and in blue triangles the ileum.

The AUC of classifying the transcriptome in colon or ileum segments was compared between the two methods.

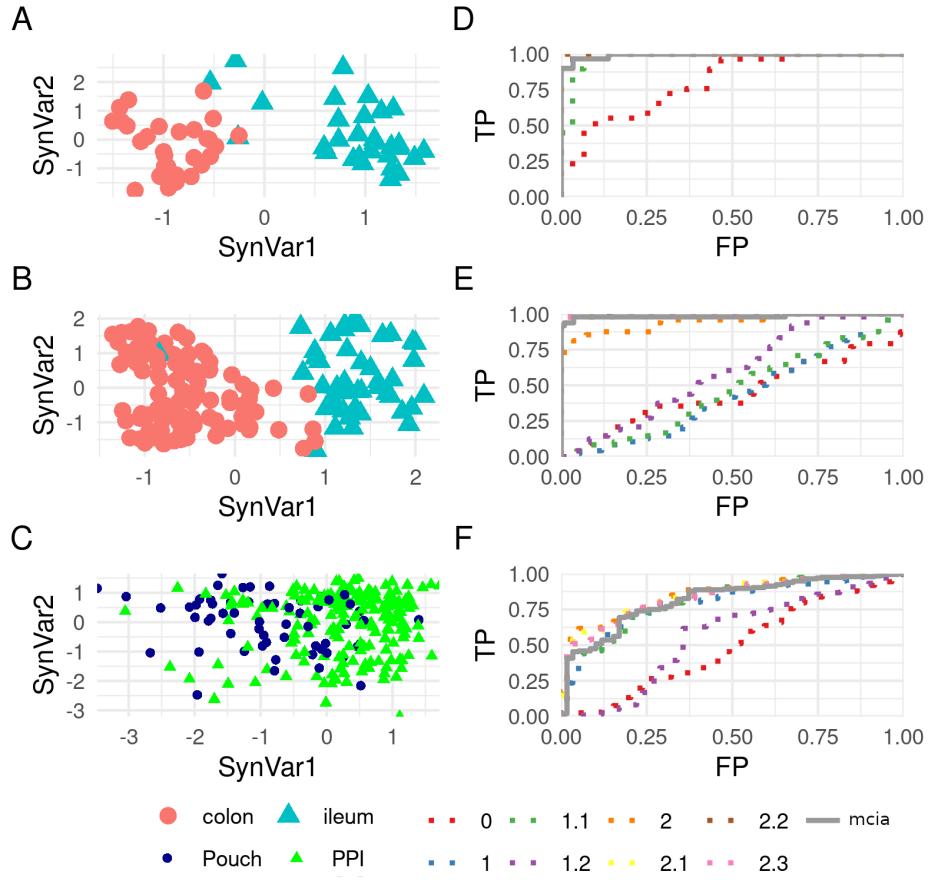


Figure 4.11: ROC curve of the different datasets with the models from RGCCA and the result with MCIA. In gray the MCIA method and with discontinued lines the models of RGCCA.

The different models selected different variables as can be seen below:

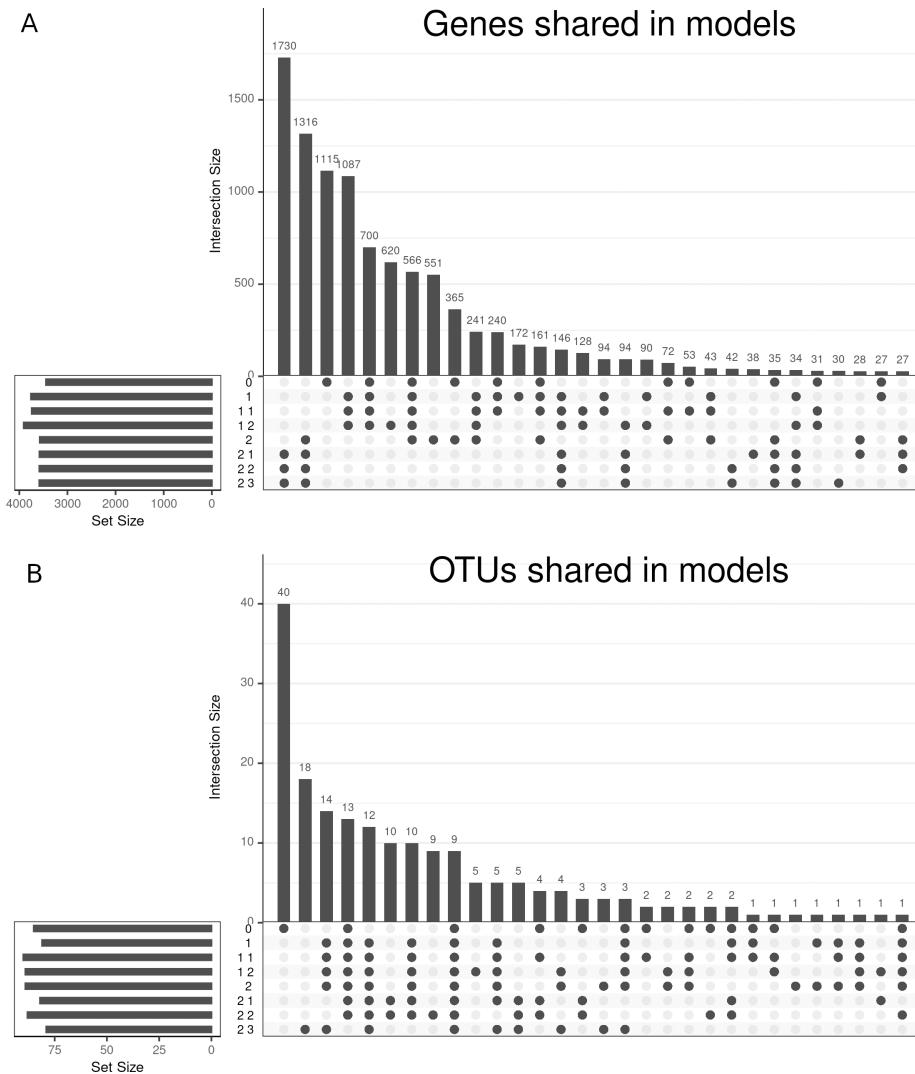


Figure 4.12: Upset plot of the variables selected on each model from 0 to 2.3 showing the intersection between them regarding genes and OTUs.

Differences and similarities between the selected features of each model can be observed on Figure 4.12. Genes are very similar between model 0 to 1.2 and between 2 to 2.3, while OTUs are very unique on model 0 and others shared between most models.

4.2.3 Hässler's dataset

In this dataset, the parameter tau behaved slightly differently than with the previous dataset but the value from the Schäfer's method for tau was close to the best value.

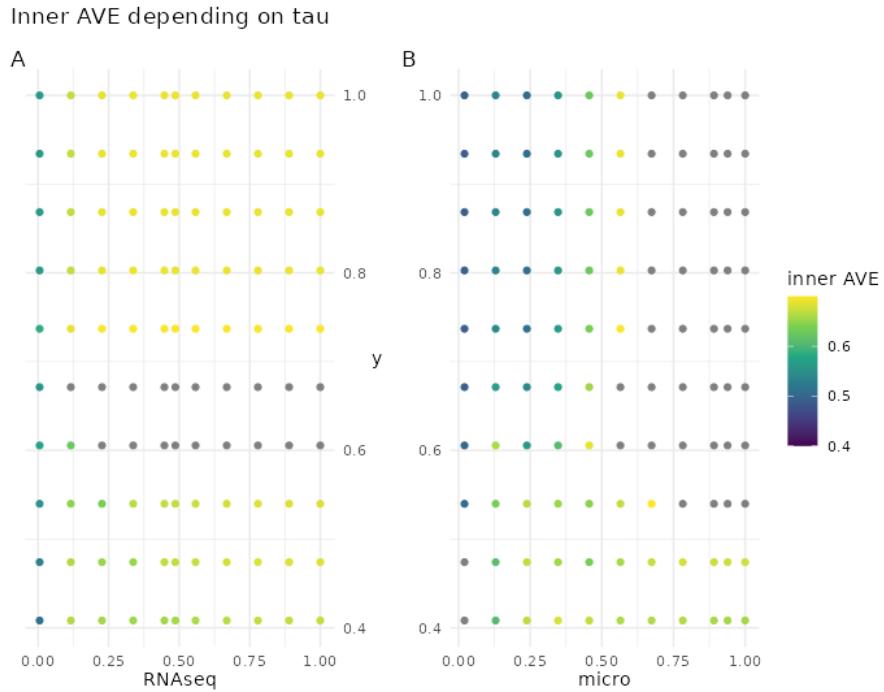
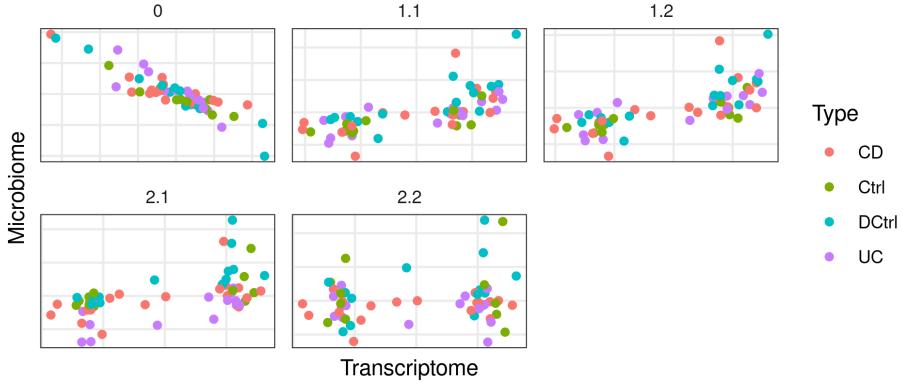


Figure 4.13: Changes on tau on the centroid scheme on the Häsler dataset affect the inner AVE score on the model 1. The panel A shows on the ordinate the RNaseq tau value, the panel B on the right, shows the tau of the microorganism; both of them show the y's tau on the abscissa.

In contrast to the HSCT's dataset, the model with the highest inner AVE was model 1.2 (inner AVE value of) but model 2.2 was close to it (inner AVE of). Model 2.2 has a relationship of 0.1 between microbiome and the host transcriptome and of 1 between the location and the host transcriptome. The microbiome block is also related by a factor of 0.1 with the demographic block and of 1 with the time block. Lastly, the time and the demographic block are related by a factor of a 0.1. In either case the family 1 and family 2 models can correctly separate by sample location (colon or ileum) but not by disease type or inflammation status as can be seen below.

Samples according to different models

A



B

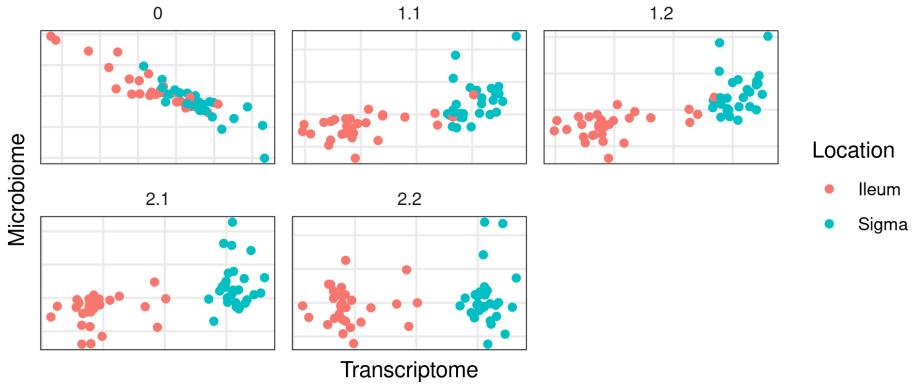


Figure 4.14: Models on the Häsler's dataset. Model 0 with just the transcriptome and microbiome data. Models 1.1 to 1.2 with transcriptome, microbiome and sample data in a single block. Models 2.1 and 2.2 with transcriptome, microbiome and sample data in multiple blocks. On the A panel colored by disease on the B panel colored by location of the sample.

There is no observable cluster of IBD samples and the other samples, showing that on this dataset the differences of the microbiome between the different type of samples are less stark.

MCIA was applied as a baseline of the integration and compared to the different models to know which one separates best colon and ileum samples.

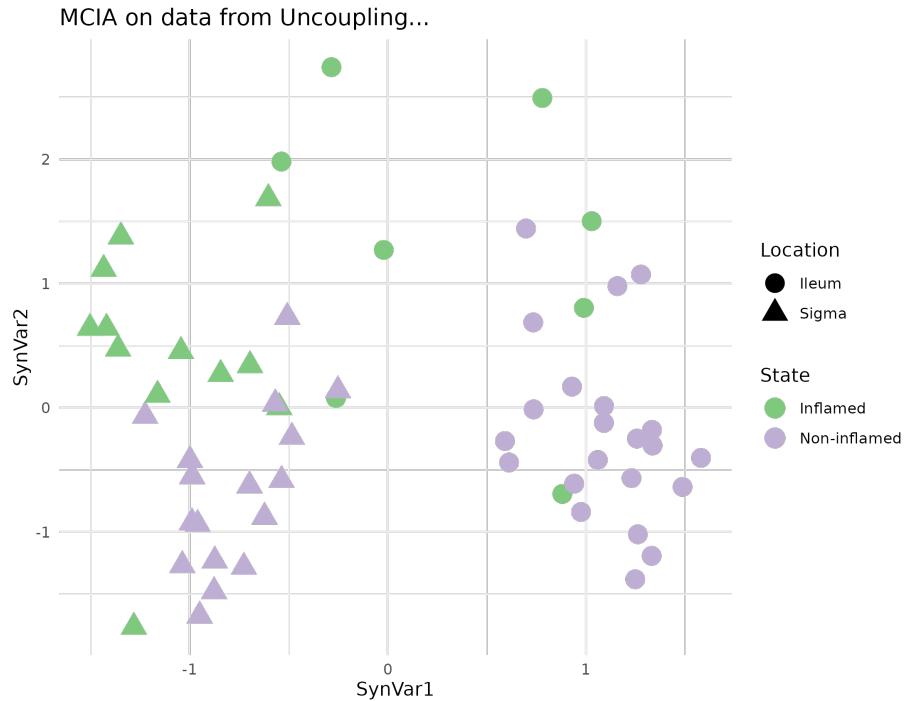


Figure 4.15: MCIA first two dimensions of the dataset colored by state, the shape is according to the location of the samples. Shows two vertical groups on the first synthetic dimension according to the location of the samples.

MCIA's AUC results was as high as the model 2.2 to classify samples according to their location. It was even better to classify the samples according to the type of sample they are: 0.6248 vs 0.5514 the best AUC from RGCCA that corresponds to model 1.2 .

4.2.4 Morgan's dataset

We tested if results of inteRmodel were consistent on this dataset with the other datasets.

Table 4.15: Relationships between the different blocks on the Morgan's dataset for model 0. 0 indicates no relationship and 1 indicates a strong relationship.

Model 0	Transcriptome	Microbiome
Transcriptome	0	1
Microbiome	1	0

Table 4.16: Relationships between the different blocks on the Morgan's dataset for model 1. 0 indicates no relationship and 1 indicates a strong relationship.

Model 1	Transcriptome	Microbiome	metadata
Transcriptome	0	0	1
Microbiome	0	0	1
metadata	1	1	0

When looking for the model that adjust better following this structure we arrived to model 1.2, described below:

Table 4.17: Relationships between the different blocks on the Morgan's dataset for model 1.2. 0 indicates no relationship and 1 indicates a strong relationship.

Model 1.2	Transcriptome	Microbiome	metadata
Transcriptome	0	0.1	0
Microbiome	0.1	0	1
metadata	0	1	0

On model two we split the invariable variables from those related to the location:

Table 4.18: Relationships between the different blocks on the Morgan's dataset for model 2. 0 indicates no relationship and 1 indicates a strong relationship.

Model 2	Transcriptome	Microbiome	Demographic	Location
Transcriptome	0	1	1	1
Microbiome	1	0	1	1
Demographic	1	1	0	0
Location	1	1	0	0

Following this split, the model that has higher inner AVE for these blocks is the following:

Table 4.19: Relationships between the different blocks on the Morgan's dataset for model 2.2. 0 indicates no relationship and 1 indicates a strong relationship.

Model 2.2	Transcriptome	Microbiome	Demographic	Location
Transcriptome	0	0.1	1	0.1
Microbiome	0.1	0	0	0
Demographic	1	0	0	0

Model 2.2	Transcriptome	Microbiome	Demographic	Location
Location	0.1	0	0	0

We also tested specifically a model from the family 2.3

Table 4.20: Relationships between the different blocks on the Morgan’s dataset for model 2.3. 0 indicates no relationship and 1 indicates a strong relationship.

Model 2.3	Transcriptome	Microbiome	Demographic	Location
Transcriptome	0	0.1	1	0.1
Microbiome	0.1	0	0	0
Demographic	1	0	0	0
Location	0.1	0	0	0

The different models were not able to separate the samples neither by location or sex.

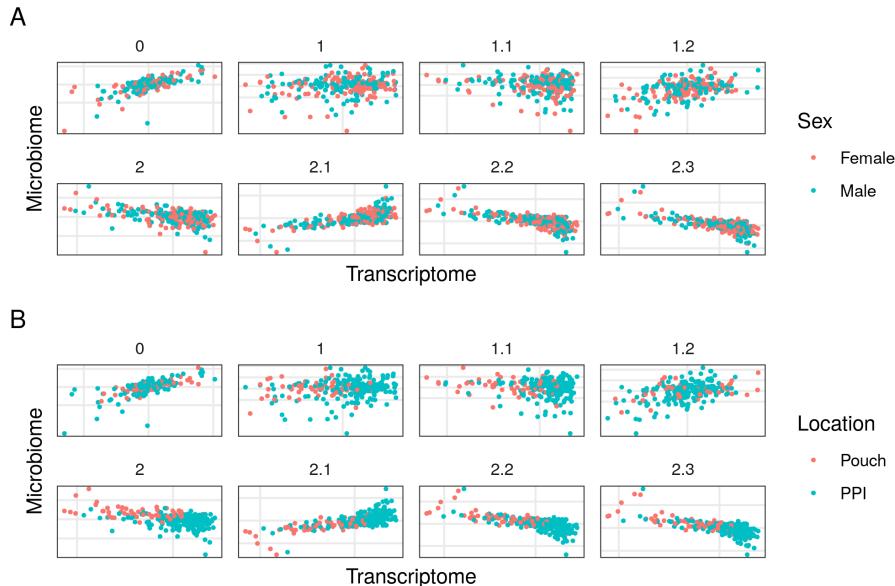


Figure 4.16: First component of the transcriptome and microbiome of the Morgan’s dataset. Model 0 without sample data. Model 1 to 1.2 with all the sample data in a single block and models 2.1 to 2.3 with sample data in several blocks. Panel A shows samples colored by sex and panel B by segment of the sample. There is no clear classification neither by location nor sex on any of the models.

Nevertheless, we compared the classification with the MCIA algorithm and still resulted that model 2.2 provide a better classification than MCIA.

Table 4.21: The models and their AVE values.

Model	inner AVE	outer AVE
0	0.4735601	0.1098639
1	0.6333592	0.115228
1.1	0.2448234	0.1104746
1.2	0.7868443	0.042266
2	0.4404123	0.108873
2.1	0.6052598	0.10749
2.2	0.6895661	0.1081315
2.3	0.6895661	0.1081315

When exploring the bootstraps of the data we found that model 1.2 is highly variable:

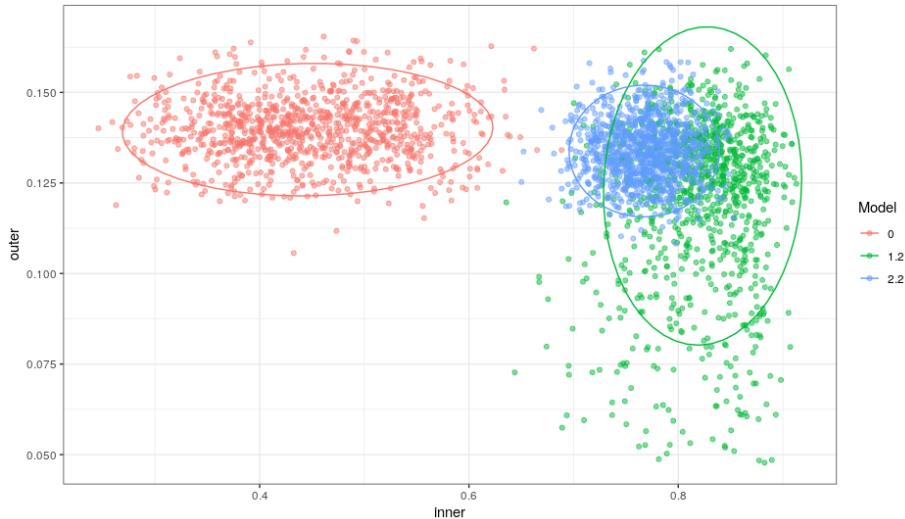


Figure 4.17: Inner and outer AVE scores of the bootstrapped models 0 1.2 and 2.2. Model 0 does not have sample data. Model 1.2 has microbiome, transcriptome and sample data in a single block and model 2.2 has microbiome, transcriptome and the sample data split in several blocks.

In addition the model 2.2 usually has a lower inner AVE compared to model 1.2.

4.2.5 Howell's dataset

This dataset was processed to confirm the results on the previous datasets. As always first we started with model 0, connecting both the RNAseq and the 16S blocks:

Table 4.22: Relationships between the different blocks on the Howell's dataset for model 0. 0 indicates no relationship and 1 indicates a strong relationship.

	Model 0	RNAseq	16S
RNAseq	0	1	
16S	1	0	

Later we look for the best model of family 1. This resulted on the following model:

Table 4.23: Relationships between the different blocks on the Howell's dataset for model 1.2. 0 indicates no relationship and 1 indicates a strong relationship.

	Model 1.2	RNAseq	16S	metadata
RNAseq	0.0	0.1	1	
16S	0.1	0.0	0	
metadata	1.0	0.0	0	

Model 1.2 4.23 was the best according to the AVE score but perform worse when attempting to recreate known biological differences via classifying samples as we can see below 4.18:

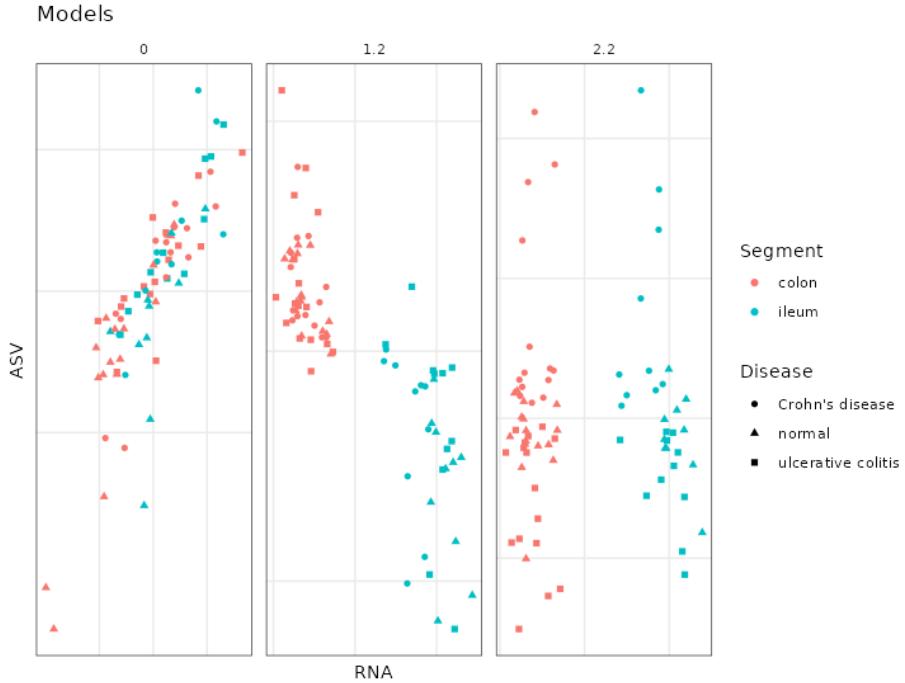


Figure 4.18: The three main models, model 0, 1.2 and 2.2 on the Howell's dataset colored by section colon, ileum and shape according to the disease: square, ulcerative colitis; triangle, normal; circle, Crohn's disease. Model 0 has just transcriptomic and microbiome data, model 1.2 has transcriptomic, microbiome and sample data and model 2.2 has transcriptomic, microbiome and sample data split in different blocks.

Model 2.2 was selected for further analysis as it describes more accurately the biology of the dataset it. Model 2.2 can be seen on [4.24](#).

Table 4.24: Relationships between the different blocks on the Howell's dataset for model 2.2. 0 indicates no relationship and 1 indicates a strong relationship.

Model 2.2	RNAseq	16S	demographics	location
RNAseq	0	0	0	1
16S	0	0	1	0
demographics	0	1	0	0.1
location	1	0	0.1	0

Model 1.2 has a 0.1 relationship between the ASV and the transcriptome and 1 between transcriptome and metadata. While model 2.2 has a relationship of 1 between location and transcriptome and demographics and ASV but only of 0.1 between demographics and location.

Table 4.25: The models and their AVE values.

Model	inner AVE	outer AVE
0	0.718098	0.111239
1.2	0.8972258	0.1660267
2.2	0.8433274	0.1659844

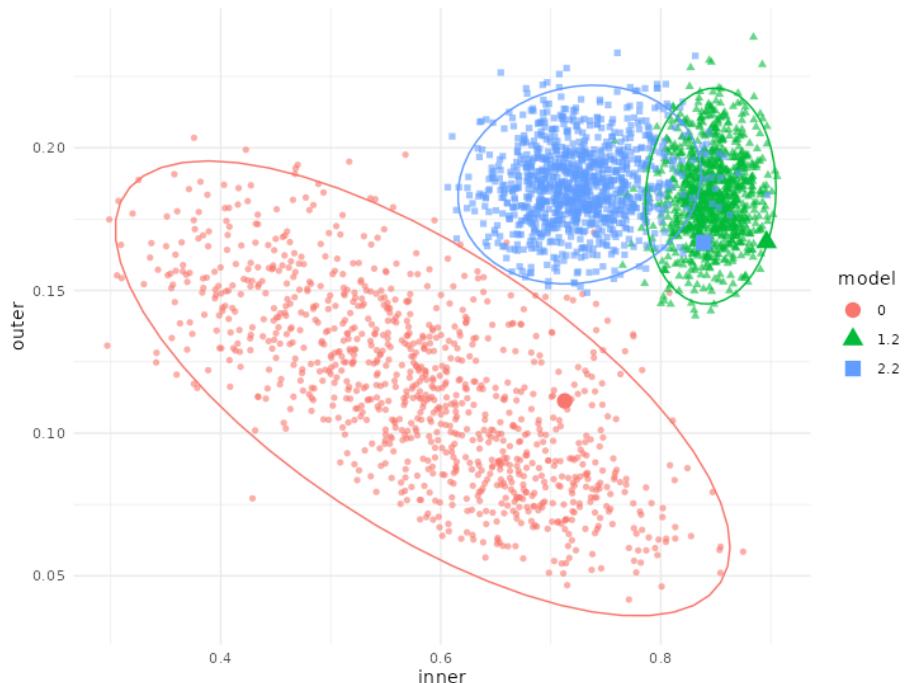


Figure 4.19: Bootstrap of the different models on the inner and outer AVE: Model 0 has just transcriptomic and microbiome data, model 1.2 has transcriptomic, microbiome and sample data and model 2.2 has transcriptomic, microbiome and sample data split in different blocks. The bigger points are the models on the original dataset.

The bootstrapping showed that model 1.2 has indeed higher inner AVE values than model 2.2 and is more stable than model 1.2. While model 0 shows a high variation according to which samples are selected.

On this dataset we also focused on the most important ASV according to the model 2.2 that were present in more than 2 samples that in total were present in the whole dataset. These ASV were summarized to a single value and then used to calculate the AUC, which was 0.85. The dot product of the ASV and genes were also calculated and used to find out which ASV are related to which genes.

<!-- # TODO continue/fix this -->

Chapter 5

Discussion

In this chapter we will summarize the main findings in relation to the broad research community and other work as well as the impact of the results to improve further research in the future or be used on clinical environments.

5.1 Preliminary steps

Quality of the initial data for integration is important for a valid integration analysis. On RNAseq and 16S analysis the sequencing data quality is important. On sequencing data it is very important to avoid contamination and have enough amount of data for the analysis. To avoid contamination it is very important the protocol how are processed the samples before the sequencing. In addition control samples can be added, a blank to control for extraneous material and a sample with known content to confirm that the sequencing worked correctly.

On bulk RNAseq the extraction procedure and sequencing protocol has been setup many years ago and works very well. Rarely there are problems with bulk RNAseq sequencing and its quality. On the contrary DNA extraction and 16S sequencing was a new procedure. Initially it was done with the guidelines of collaborators. Later, when we did ourselves we did not include control samples but after some problems we started adding at least blank samples to identify those bacteria that might come with the solvent or be due to contamination.

Once the 16S data was obtained we initially processed it to obtain OTUs. OTUs were the standard some years back. However, OTUs are not comparable between studies even those that use the same primers. For this reason, and after a suggestion from a reviewer, we moved to process later 16S sequencing datasets to obtain ASV. ASV allow to compare the taxonomic imputation between studies using the same primers. However, comparing 16S taxa ASV or OTUs is hard and selecting the right tool to compare them is important [198].

It is also worth to keep in mind that several species have variable number of 16S rRNA genes. Higher sequences counts of certain 16S might not mean higher abundance of that species compared to another with lower 16S counts. However,

the exact copy number status may change even within the same bacterial species, making the correction difficult [199]. It is possible to accurately correct for copy number variation on mock populations where the species and the genomes are known (or at least the 16S rRNA), but harder on samples which content is unknown.

Furthermore, the precision of 16S sequencing for classification of taxa is not enough to understand its role on the gut. Adherent invasive cells, are cells with same genetic content that show different behavior [200]. These microbiome is known to be present on patients with IBD. Thus even with the complete sequence play a different role on the health of the patients.

Most of these steps were out of my control as they were performed by a lab teammate or by collaborators. Other concerns are currently unavoidable or could not have been found beforehand.

5.1.1 The datasets

There is not a methodology to calculate the size of cohorts for interaction or multiomic studies. There are no clear rules about which alpha power or which kind of relations are tested. This might be due to a lack of mathematical background and modelization of the relations on the biological field. Further research on this area might help finding which kind of relationships can be found given certain dataset size. In addition to the highly local and not generalizable interactions that happen on biological samples. Usually size of the datasets is determined from practical reasons: either costs or patient recruitment on protocols.

There are some efforts to simulate multi-omic datasets [201]. They usually focus on RNA-seq, ATAC-seq (DNase-seq), ChIP-seq, small RNA-seq, Methyl-seq or proteomics. To my knowledge there is no accurate generator of 16S datasets or other microbiome datasets. This made impossible to simulate and compare different tools on a dataset with known relationships. Current approaches focus on comparing tools on (several) previously published datasets [202], an approach that we have taken too. This approach was not used to compare different tools, that we also do it, but to validate findings of one dataset in other datasets.

There is not a golden dataset for integration. There are many possible relationships between variables and different ways these relationships might be: regulated DNA, protein recruitment, transcription factors, siRNA regulation. Not a single one can be measured on a sufficiently detailed timescale that it can matter and as a result we are left with trying to guess what are the the relationships between variables. In addition, this is compound by the lack of explanations about how this relationships might come, despite other indications.

Comparing different datasets is complicated because each is collected with different goals and processed differently. In addition, there is not a resource were datasets of publications are collected or the relationships between different datasets is not shared. Authors upload their data to different, not centralized, data repositories, such as, gene expression omnibus ([GEO](#)), European Genome-Phenome Archive ([EGA](#)), European Nucleotide Archive ([ENA](#)), among others.

Authors might provide the processed data as supplementary material on their articles. Some projects whose primary purpose is providing data for the community establishing their own dedicated sites to store the data [203].

Finding different datasets for very similarly purposes is very difficult. And once it is found there might be batch effects. There are tools to overcome this, but currently only work if they share some features in common [204]. This usually means having undergone similar RNA sequencing procedures.

All this made finding annotated, appropriate and similar datasets difficult. We looked up for the most similar datasets in order to be able to confirm our results outside our own cohorts. On this thesis there were two datasets collected and sequenced: the HSCT and the BARCELONA dataset.

As explained on [methods](#), the HSCT dataset is a very special cohort of patients undergoing hematopoietic stem cell transplant. This treatment is reserved to patients whose all the other treatment failed and this is the only way to reach remission. This is common on patients with long time CD. These patients are highly characterized and there is follow up data for several years. However, it does not include UC patients and they are not representative of the IBD, or even CD, patients.

On the HSCT dataset microbiome features were OTUs. OTUs can not be imputed afterwards to ASV. As such, the annotation of the 16S data is not the same as in the others datasets.

The BARCELONA dataset includes samples from CD and UC of an ongoing study. Similar to the HSCT dataset, patients on this study were followed up for up to a year. The patients were younger and had less years with the disease, which could provide with more insights on the initial relationships between the microbiome and the mucosa of the IBD.

However, the data quality of BARCELONA was not good enough to make reliable analysis and confidently extract hypothesis or relationships. It is not clear what happened and as a consequence it is not clear how to avoid such problems on the future. It could be a problem of the original DNA extraction and/or of its sequencing process which did not include both positive and negative controls.

What happened with the BARCELONA dataset -and the organoids cohort not described here- highlights the importance of data quality checks. On the BARCELONA cohort despite no batch effect or other quality issues with the data as checked with `experDesign`, the diversity indices made impossible using it. The organoids cohort is a dataset that was sequenced following the `experDesign` recommendations for distribution of samples on different batches. However, a batch effect was found. The batch effect was created on the lab process before the samples' sequencing. Caution and a good relationship with the data sample and data generator is important to discover these kind of problems and ensure the quality of the data.

Other datasets used from published sourced were assumed they had already passed enough controls and had a good quality. Nevertheless, they were screened to avoid quality issues.

The Puget's dataset dataset provided a good benchmark to test the methods and

understand how RGCCA works. It is a completely different type of data (except for the microarray that is similar to the RNAseq). But we were not as much interested on the biology as on learning about the methods and possibilities of integration.

Hässler data were obtained using the same sequencing techniques from endoscopic biopsies as our dataset HSCT and Barcelona and it is of the same disease/field. The 16S data was very similar to the The confirmation that the inteRmodel approach works on it it helped to continue forward.

The taxonomy of the different datasets was done differently. After the first two datasets it was used the SILVA database to annotate the ASV.

Morgan's dataset is related to IBD but it is from a cohort of patients that underwent colectomy and samples are specific of the pouch or pre-pouch ileum, there are no healthy samples and there is no follow up. It made very unlikely that a classification of the location could be achieved and the classification of the samples according to the microbiota could not be based on the disease (as all of them had undergone the same procedure with the same disease). There seems to be gradation on the models on 4.16 that could partially be explained by different degrees of inflammation.

Howell's dataset is very similar to our BARCELONA dataset but on pediatric cases. It includes both CD and UC (and controls). The time with the disease of these patients is much lower, and they have might followed less treatments and probably have not had any surgery

The Cristian's dataset was also imputed with SILVA but using a different database version.

5.1.2 The methods

As seen on the introduction there are many methods are available. There are frequent releases of new tools and methods. The most up to date list of tools might be added to a [collaborative list](#). Between them methods are very different in how they can be used and how they can be classified. The quality of the software and methods also differs. Some of them were tested several datasets but their most important validation process undergone is the mathematical validation they have.

With the increase of tools there have been increasingly important to compare different tools. There are reviews of different tools on the same datasets [205], some are more theoretical [ref:needed], others are focused on a different field [99].

Of all these methods very few have been applied on IBD datasets. Recently there has been an article focused on integration on IBD [148]. On this publication the authors suggest that one must be mindful of the gap between the experimental conditions and the real world. It also encourages to collect more data about the exposome (the stimuli patients have). It ends up advising to set up guidelines for multi-omic studies tailored to the field, coordinate in a global framework to prevent redundant studies and ensure efficient funding and resources and

disseminate training and education on computational approaches to analyze multi-omic datasets.

On IBD, many studies focus on finding some genes or bacteria to answer a narrow question they have in mind, like which bacteria is related to inflammation. On this thesis, the focus was on finding a good representation of the disease that allowed to identify genes and bacteria that were relevant to the disease. We made the assumptions that the microbiome and the transcriptome are related. This assumption is backed up by several other previous studies supporting this relationship or others [40, 41, 206–208].

However, it is also known the role of other factors that are outside the omics dataset. To guide the search of which of these variables are important tools that relate the variance of a block with other variables, both numeric and categoric, are needed.

PERMANOVA, **adonis** and **globaltest** worked well to identify which variables about the samples were important. But they do not provide variable selection or give any insight into which specific microbial species are driving the association between the microbiome and the variables [209].

In addition, we could miss some other important variables. Sudhakar *et. al.* [148] recommend being conscious of the gap between the data available and the biological process. However, even if we missed them, we probably have not collected it or it is not available, there is nothing at this point that can be done. This also enters in conflict with a principle of data protection: the minimum sufficient information should be collected. We might not identify a relevant variable but to identify it we would need to collect too much information from the patients and for little or no clear benefits.

We tried to find which genes and bacteria are correlated between them using WGCNA. It is a tool designed to find common co-occurring patterns based on correlations. It requires homogeneous samples, with a minimum of 12 samples for condition. When applied to the whole dataset there might be too much variance in order of WGCNA to find the proper signal. This might be the reason why it failed to achieve a good fit on the scale free topology with around 100 of mean connectivity. In addition, having microbiome and RNASeq on the same matrix, would probably be hard for the process to find good relationships if we applied the same normalization process to both of them without scaling. We could have tried to make smaller groups and then compare the modules between them but it groups would be too small because samples were from multiple segments and conditions.

We briefly considered using **STATegRa**. But it is not possible to select which interactions between the blocks exists and by that time we already knew it was important to consider several of the variables collected from the patients.

BaseSet did not work for its intended usage on this thesis. It failed because it is computationally expensive to calculate the likelihood of 1500 variables, there are too many combinations. In addition, the numeric precision of said calculations suffers from the floating point problems and must be considered carefully. To support multiplying more than 1000 float numbers a different strategy such as using log values might be better. We could not come up with a better strategy to find all the combinations needed, perhaps a better method exists that could

be used to find which are the terms more influential to the end result.

The development of the `experDesign` package helped avoid batch effects due to the `experDesign` package. This package might help to improve the quality of the datasets and to expand previously sequenced datasets. However, as seen on the previous section, this does not prevent all problems with batch effects and still batch effects resulting on a less useful experiment might get through. As discussed on the related publication, there are several tools already focused on this problem: `OSAT` ([210]), `anticlust` ([211]) and `Omixer` ([212]). But these tools have some shortcomings, that are covered by `experDesign`, `OSAT` cannot handle missing values and does not work well for arbitrary batches. `anticlust` only accepts numerical variables but it is based on a mathematical theorem that makes it very powerful. `Omixer` has bugs that prevent comparing with the other tools with no possible workaround.

We selected MCIA as a baseline to compare our method because it works well and has a good documentation as well as it is fairly used on the computational world. The method was developed after RGCCA and recently there have been publications that show that it outperforms other methods on its versatility on different contexts [202]. On the dataset analyzed we found it was very competitive but this will be discussed on section 5.3 .

5.2 Designing models

Previous publications using RGCCA on IBD focused on validating inflammation markers genes DUOX2 and APOA1 as inflammation predictors ([80]) from previously published articles [213]. Some publication tried to summarize the existing relationships on IBD [79].

Modeling the relationships on RGCCA the connections between blocks had to be modified. Also what belongs to a block should be modified. The features selected by RGCCA are highly dependent on which connections are made.

If one has preexisting theories about the data, a specific model can be used stating these known or hypothetical relationships. However, if new relationships are being explored or no prior beliefs on the data are held the models should be created with random links between blocks, and evaluate which model is better.

The connections tested required that all models should be connected and no isolated blocks were left, all blocks should be indirectly connected to other blocks. This avoids optimizing two different networks of blocks that are not connected between them. Thus, forcing the model to represent all the information.

Typically blocks are defined

5.3 Evaluating models

To evaluate a model RGCCA provides the average variance explained (AVE), inner and outer. Inner AVE is for how well do all the canonical dimensions correlate with the design of the experiment, so it a measure of how good the

model is. While outer AVE is a measure of how well do the variables of each block correlate with the canonical dimension, so it measures the agreement between the variables and the canonical dimensions. Depending on the goals of the research one or the other should be used. If we are more interested on the model of the relationships the inner AVE makes more sense.

Furthermore, to evaluate a design bootstrapping can be used to know how well the design does apply to a variety of data. Another option is to use an external cohort to validate the same model, or using a different method to see if it finds the same relationships or explains the data as accurately. Of the multiple methods available we used [MCIA](#) [214]. Which was compared by looking at the area under the curve for classifying the samples according to their location.

Besides a way to compare methods, these models do need to be evaluated by the insights they provide on the biological system they are being applied to, in our case the Crohn's disease. In this article we did not look in depth to the biological relevance of the microorganisms and genes found.

The procedure of separating independent variables in their own block of data and later search the best model that fits the data provides a good strategy that should be consider for integration efforts.

The procedural method of searching a model and testing them is implemented on [inteRmodel](#). But the most important thing is to consider which variables are independent of which and if they can be separated into a block for later usage on the modeling.

It is known that mucosal transcriptome is related to localization of the samples [ref:needed]. The difference is so great that many times the colon and ileum samples are analyzed separately.

The variability of microbiome has made challenging to find clear patterns on what it is related. It is more related to the disease and other variables of the patients.

Time is an important variable when modelling the disease, if multiple timepoints are taken they should be taken into account to identify the state of the disease for each patient. As well as they multiple samples with microbiota from the same patient provide a common microbiome background, which can help to identify altered microbiome states later on. Due to technical challenges very few datasets provide data from the same patient on multiple locations.

[215] A paper about multi-omics and microbiome...

[94] advice and recommendations on software engineering and reproducibility practices to share a comprehensive awareness with new researchers in multi-omics for end-to-end workflow.

5.4 Relevance for other research

It is hard to provide more information that can be later used by researchers on the wet lab.

Paper about using transcriptomics to infer inflammation without colonoscopy [216]

There is a disconnect between the computational side and the experimental side, driven by the difficulty to think an experiment to test the new information that multi-omic experiments provide.

Many combinations possible that are hard to explore, further research on how to reduce the space of possible combinations of bacteria or evaluate which combinations are more important might be useful on the future. As this might help focus on the most promising bacteria.

5.5 Implications of research

Translational research? How to apply this results ?

Sequence just the ASV on patients to classify them on disease might be an option that would require further clinical validation.

Selecting which genes are related to the microorganisms is will require also further validation (for which I did not have the creativity to think of).

The several environmental factors highly affect the disease, so analysis or comparisons without taking into account them might provide misleading or false results.

Multi-omics seems to focus on metagenomics, metatranscriptomics and metaproteomics and abandon plain 16S sequencing [217].

To study complex systems, new technologies like “organ-on-chip” or more specifically “gut-on-chip” are being developed [218]. By introducing gut microbiota, these system will be of great help in the stud of the interaction of the gut microbiota dn the intestinal epithelium.

Chapter 6

Conclusions

Microbiome under some dataset can classify the patients according to their disease. Doing so reliable might take some time. It is hard to make it generalizable.

Overoptimizing for a dataset might be possible but so far we have not seen this, on the contrary on different dataset the models of connections seem consistently even if the particular taxa do not show a great overlap.

If we had to summarize all the work in one sentence we would say that...

Chapter 7

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Azu

Juanjo

Pau + grup

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References

1. Raine T, Verstockt B, Kopylov U, Karmiris K, Goldberg R, Atreya R, et al. [ECCO topical review: Refractory inflammatory bowel disease](#). Journal of Crohn's and Colitis. 2021;15:1605–20.
2. Jairath V, Feagan BG. [Global burden of inflammatory bowel disease](#). The Lancet Gastroenterology & Hepatology. 2020;5:2–3.
3. Burisch J, Munkholm P. [The epidemiology of inflammatory bowel disease](#). Scandinavian Journal of Gastroenterology. 2015;50:942–51.
4. Human Microbiome Project Consortium BA, Nelson KE, Pop M, Creasy HH, Giglio MG, Huttenhower C, et al. [A framework for human microbiome research](#). Nature. 2012;486:215–21.
5. Mukhopadhyay I, Hansen R, El-Omar EM, Hold GL. [IBD—what role do Proteobacteria play?](#) Nature Reviews Gastroenterology & Hepatology. 2012;9:219–30.
6. Zhang Y-Z, Li Y-Y. [Inflammatory bowel disease: pathogenesis](#). World Journal of Gastroenterology. 2014;20:91–9.
7. Hugot J-P. [Genetic origin of IBD](#). Inflammatory Bowel Diseases. 2004;10:S11–5.
8. Silva FAR, Rodrigues BL, Ayrizono M de LS, Leal RF. [The Immunological Basis of Inflammatory Bowel Disease](#). Gastroenterology Research and Practice. 2016;2016:2097274.
9. de Mattos BRR, Garcia MPG, Nogueira JB, Paiatto LN, Albuquerque CG, Souza CL, et al. [Inflammatory Bowel Disease: An Overview of Immune Mechanisms and Biological Treatments](#). Mediators of Inflammation. 2015;2015:493012.
10. McGovern DPB, Kugathasan S, Cho JH. [Genetics of Inflammatory Bowel Diseases](#). Gastroenterology. 2015;149:1163–1176.e2.
11. Satsangi J, Silverberg MS, Vermeire S, Colombel J-F. [The Montreal classification of inflammatory bowel disease: controversies, consensus, and implications](#). Gut. 2006;55:749–53.
12. Horowitz JE, Warner N, Staples J, Crowley E, Gosalia N, Murchie R, et al. [Mutation spectrum of NOD2 reveals recessive inheritance as a main driver of early onset crohn's disease](#). Scientific Reports. 2021;11:5595.
13. Kumar M, Garand M, Al Khodor S. [Integrating omics for a better understanding of inflammatory bowel disease: A step towards personalized medicine](#). Journal of Translational Medicine. 2019;17:419.
14. Jostins L, Ripke S, Weersma RK, Duerr RH, McGovern DP, Hui KY, et al. [Host–microbe interactions have shaped the genetic architecture of inflammatory bowel disease](#). Nature. 2012;491:119–24.

15. Momozawa Y, Dmitrieva J, Théâtre E, Deffontaine V, Rahmouni S, Charlotteaux B, et al. **IBD risk loci are enriched in multigenic regulatory modules encompassing putative causative genes.** Nature Communications. 2018;9.
16. Khanna S, Tosh PK. **A Clinician's Primer on the Role of the Microbiome in Human Health and Disease.** Mayo Clinic Proceedings. 2014;89:107–14.
17. Swidsinski A, Ladhoff A, Pernthaler A, Swidsinski S, LoeningBauke V, Ortner M, et al. **Mucosal flora in inflammatory bowel disease.** Gastroenterology. 2002;122:44–54.
18. Tamboli CP, Neut C, Desreumaux P, Colombel JF. **Dysbiosis in inflammatory bowel disease.** Gut. 2004;53:1–4.
19. Ott SJ. **Reduction in diversity of the colonic mucosa associated bacterial microflora in patients with active inflammatory bowel disease.** Gut. 2004;53:685–93.
20. Kostic AD, Xavier RJ, Gevers D. **The microbiome in inflammatory bowel disease: Current status and the future ahead.** Gastroenterology. 2014;146:1489–99.
21. Sender R, Fuchs S, Milo R. **Revised Estimates for the Number of Human and Bacteria Cells in the Body.** PLOS Biology. 2016;14:e1002533.
22. Sankarasubramanian J, Ahmad R, Avuthu N, Singh AB, Guda C. **Gut microbiota and metabolic specificity in ulcerative colitis and crohn's disease.** Frontiers in Medicine. 2020;7.
23. Lopez-Siles M, Martinez-Medina M, Busquets D, Sabat-Mir M, Duncan SH, Flint HJ, et al. **Mucosa-associated Faecalibacterium prausnitzii and Escherichia coli co-abundance can distinguish Irritable Bowel Syndrome and Inflammatory Bowel Disease phenotypes.** International journal of medical microbiology: IJMM. 2014;304:464–75.
24. Ferrer-Picón E, Dotti I, Corraliza AM, Mayorgas A, Esteller M, Perales JC, et al. **Intestinal Inflammation Modulates the Epithelial Response to Butyrate in Patients With Inflammatory Bowel Disease.** Inflammatory Bowel Diseases. 2020;26:43–55.
25. Darfeuille-Michaud A, Neut C, Barnich N, Lederman E, Di Martino P, Desreumaux P, et al. **Presence of adherent Escherichia coli strains in ileal mucosa of patients with Crohn's disease.** Gastroenterology. 1998;115:1405–13.
26. Tsilingiri K, Barbosa T, Penna G, Caprioli F, Sonzogni A, Viale G, et al. **Probiotic and postbiotic activity in health and disease: comparison on a novel polarised ex-vivo organ culture model.** Gut. 2012;61:1007–15.
27. Vanderpool C, Yan F, Polk BD. **Mechanisms of probiotic action: Implications for therapeutic applications in inflammatory bowel diseases.** Inflammatory Bowel Diseases. 2008;14:1585–96.
28. Isaacs K, Herfarth H. **Role of probiotic therapy in IBD.** Inflammatory Bowel Diseases. 2008;14:1597–605.
29. Plaza-Diaz J, Ruiz-Ojeda FJ, Gil-Campos M, Gil A. **Mechanisms of action of probiotics.** Advances in Nutrition. 2019;10:S49–66.
30. Morelli L, Capurso L. **FAO/WHO guidelines on probiotics: 10 years later.** Journal of Clinical Gastroenterology. 2012;46:S1.
31. Okumura R, Takeda K. **Roles of intestinal epithelial cells in the maintenance of gut homeostasis.** Experimental & Molecular Medicine. 2017;49:e338–8.
32. Faria AMC, Mucida D, McCafferty D-M, Tsuji NM, Verhasselt V. **Tolerance and inflammation at the gut mucosa.** Clinical & Developmental Immunology. 2012;2012:738475.

33. Hisamatsu T, Kanai T, Mikami Y, Yoneno K, Matsuoka K, Hibi T. **Immune aspects of the pathogenesis of inflammatory bowel disease.** Pharmacology & Therapeutics. 2013;137:283–97.
34. Michielan A, D'Incà R. **Intestinal Permeability in Inflammatory Bowel Disease: Pathogenesis, Clinical Evaluation, and Therapy of Leaky Gut.** Mediators of Inflammation. 2015;2015:628157.
35. Mayorgas A. **Human Primary Organoid-Derived Epithelial Monolayers as a Novel Strategy for the Study of Adherent Invasive Escherichia coli pathogenicity and the effects of Postbiotics on Intestinal Epithelial Function.** PhD thesis. 2021.
36. Neurath MF, Fuss I, Kelsall BL, Presky DH, Waegell W, Strober W. **Experimental granulomatous colitis in mice is abrogated by induction of TGF-beta-mediated oral tolerance.** Journal of Experimental Medicine. 1996;183:2605–16.
37. Corraliza AM, Ricart E, López-García A, Carme Masamunt M, Veny M, Esteller M, et al. Differences in Peripheral and Tissue Immune Cell Populations Following Haematopoietic Stem Cell Transplantation in Crohn's Disease Patients. Journal of Crohn's and Colitis. <https://doi.org/10.1093/ecco-jcc/jjy203>.
38. Strachan DP. **Hay fever, hygiene, and household size.** BMJ : British Medical Journal. 1989;299:1259–60.
39. Scudellari M. **News feature: Cleaning up the hygiene hypothesis.** Proceedings of the National Academy of Sciences of the United States of America. 2017;114:1433–6.
40. Thomas GAO, Rhodes J, Green JT. **Inflammatory bowel disease and smoking—a review.** Official journal of the American College of Gastroenterology | ACG. 1998;93:144149.
41. Cornish JA, Tan E, Simillis C, Clark SK, Teare J, Tekkis PP. **The risk of oral contraceptives in the etiology of inflammatory bowel disease: a meta-analysis.** The American Journal of Gastroenterology. 2008;103:2394–400.
42. Kaufmann HJ, Taubin HL. **Nonsteroidal anti-inflammatory drugs activate quiescent inflammatory bowel disease.** Annals of Internal Medicine. 1987;107:513–6.
43. Bitton A, Dobkin PL, Edwardes MD, Sewitch MJ, Meddings JB, Rawal S, et al. **Predicting relapse in Crohn's disease: a biopsychosocial model.** Gut. 2008;57:1386–92.
44. Baumgart DC, Sandborn WJ. **Crohn's disease.** The Lancet. 2012;380:1590–605.
45. Khanna S, Shin A, Kelly CP. **Management of clostridium difficile infection in inflammatory bowel disease: Expert review from the clinical practice updates committee of the AGA institute.** Clinical Gastroenterology and Hepatology. 2017;15:166–74.
46. Guardiola J, Lobatón T, Cerrillo E, Ferreiro-Iglesias R, Gisbert JP, Domènech E, et al. **Recommendations of the Spanish Working Group on Crohn's Disease and Ulcerative Colitis (GETECCU) on the utility of the determination of faecal calprotectin in inflammatory bowel disease.** Gastroenterología y Hepatología (English Edition). 2018;41:514–29.
47. Sands BE. **Biomarkers of Inflammation in Inflammatory Bowel Disease.** Gastroenterology. 2015;149:1275–1285.e2.
48. Corraliza Márquez A. **Immune mechanisms involved in inducing remission in Crohn's disease patients undergoing hematopoietic stem cell transplant.** PhD thesis. 2019.

49. Bassolas Molina H. *Resposta T específica contra antígens de la microbiota comensal en la malaltia de Crohn i inhibició de ROR?*t com a estratègia terapèutica. PhD thesis. 2018.
50. Daperno M, D'Haens G, Van Assche G, Baert F, Bulois P, Maunoury V, et al. *Development and validation of a new, simplified endoscopic activity score for crohn's disease: The SES-CD.* Gastrointestinal Endoscopy. 2004;60:505–12.
51. Best WR, Bechtel JM, Singleton JW, Kern F. *Development of a Crohn's Disease Activity Index: National Cooperative Crohn's Disease Study.* Gastroenterology. 1976;70:439–44.
52. Bhattacharya A, Rao BB, Koutroubakis IE, Click B, Vargas EJ, Regueiro M, et al. *Silent crohn's disease predicts increased bowel damage during multiyear follow-up: The consequences of under-reporting active inflammation.* Inflammatory Bowel Diseases. 2016;22:2665–71.
53. Peyrin-Biroulet L, Loftus EVJ, Colombel J-F, Sandborn WJ. *The natural history of adult crohn's disease in population-based cohorts.* Official journal of the American College of Gastroenterology | ACG. 2010;105:289297.
54. Etchevers MJ, Aceituno M, García-Bosch O, Ordás I, Sans M, Ricart E, et al. *Risk factors and characteristics of extent progression in ulcerative colitis.* Inflammatory Bowel Diseases. 2009;15:1320–5.
55. Boonstra K, van Erpecum KJ, van Nieuwkerk KMJ, Drenth JPH, Poen AC, Witteman BJM, et al. *Primary sclerosing cholangitis is associated with a distinct phenotype of inflammatory bowel disease.* Inflammatory Bowel Diseases. 2012;18:2270–6.
56. Mark-Christensen A, Laurberg S, Haboubi N. *Dysplasia in Inflammatory Bowel Disease: Historical Review, Critical Histopathological Analysis, and Clinical Implications.* Inflammatory Bowel Diseases. 2018;24:1895–903.
57. Schieffer KM, Williams ED, Yochum GS, Koltun WA. *Review article: the pathogenesis of pouchitis.* Alimentary Pharmacology & Therapeutics. 2016;44:817–35.
58. Schroeder KW, Tremaine WJ, Ilstrup DM. *Coated Oral 5-Aminosalicylic Acid Therapy for Mildly to Moderately Active Ulcerative Colitis.* New England Journal of Medicine. 1987;317:1625–9.
59. Irvine EJ. *Development and Subsequent Refinement of the Inflammatory Bowel Disease Questionnaire: A Quality-of-Life Instrument for Adult Patients with Inflammatory Bowel Disease.* Journal of Pediatric Gastroenterology & Nutrition. 1999;28 Supplement:S23–7.
60. Travis SPL, Schnell D, Krzeski P, Abreu MT, Altman DG, Colombel J-F, et al. *Developing an instrument to assess the endoscopic severity of ulcerative colitis: The ulcerative colitis endoscopic index of severity (UCEIS).* Gut. 2012;61:535–42.
61. Travis SPL, Stange EF, Lémann M, Öresland T, Chowers Y, Forbes A, et al. *European evidence based consensus on the diagnosis and management of Crohn's disease: current management.* Gut. 2006;55 suppl 1:i16–35.
62. Akobeng AK, Zhang D, Gordon M, MacDonald JK. Oral 5-aminosalicylic acid for maintenance of medically-induced remission in Crohn's disease. Cochrane Database of Systematic Reviews. 2016. <https://doi.org/10.1002/14651858.CD003715.pub3>.
63. Feller M, Huwiler K, Schoepfer A, Shang A, Furrer H, Egger M. *Long-term antibiotic treatment for crohn's disease: Systematic review and meta-analysis of placebo-controlled trials.* Clinical Infectious Diseases. 2010;50:473–80.

64. Prantera C, Scribano ML. [Antibiotics and probiotics in inflammatory bowel disease: Why, when, and how.](#) Current Opinion in Gastroenterology. 2009;25:329333.
65. Rezaie A, Kuenzig ME, Benchimol EI, Griffiths AM, Otley AR, Steinhardt AH, et al. Budesonide for induction of remission in Crohn's disease. Cochrane Database of Systematic Reviews. 2015. <https://doi.org/10.1002/14651858.CD000296.pub4>.
66. Lichtenstein GR, Hanauer SB, Sandborn WJ, Gastroenterology TPPC of the AC of. [Management of crohn's disease in adults.](#) Official journal of the American College of Gastroenterology | ACG. 2009;104:465483.
67. Ouellette AJ, Bevins CL. [Paneth cell defensins and innate immunity of the small bowel.](#) Inflammatory Bowel Diseases. 2001;7:43–50.
68. Warner B, Johnston E, Arenas-Hernandez M, Marinaki A, Irving P, Sanderson J. [A practical guide to thiopurine prescribing and monitoring in IBD.](#) Frontline Gastroenterology. 2018;9:10–5.
69. Chande N, Patton PH, Tsoulis DJ, Thomas BS, MacDonald JK. Azathioprine or 6-mercaptopurine for maintenance of remission in Crohn's disease. Cochrane Database of Systematic Reviews. 2015. <https://doi.org/10.1002/14651858.CD000067.pub3>.
70. Gisbert JP, Linares PM, Mcnicholl AG, Maté J, Gomollón F. [Meta-analysis: the efficacy of azathioprine and mercaptopurine in ulcerative colitis.](#) Alimentary Pharmacology & Therapeutics. 2009;30:126–37.
71. Peyrin-Biroulet L, Lémann M. [Review article: remission rates achievable by current therapies for inflammatory bowel disease.](#) Alimentary Pharmacology & Therapeutics. 2011;33:870–9.
72. Billiou V, Sandborn WJ, Peyrin-Biroulet L. [Loss of response and need for adalimumab dose intensification in crohn's disease: A systematic review.](#) Official journal of the American College of Gastroenterology | ACG. 2011;106:674684.
73. Hwang JM, Varma MG. [Surgery for inflammatory bowel disease.](#) World Journal of Gastroenterology : WJG. 2008;14:2678–90.
74. Gardiner KR, Dasari BVM. [Operative Management of Small Bowel Crohn's Disease.](#) Surgical Clinics of North America. 2007;87:587–610.
75. Lewis RT, Maron DJ. [Efficacy and complications of surgery for crohn's disease.](#) Gastroenterology & Hepatology. 2010;6:587–96.
76. Corraliza AM, Ricart E, López-García A, Carme Masamunt M, Veny M, Esteller M, et al. Differences in Peripheral and Tissue Immune Cell Populations Following Haematopoietic Stem Cell Transplantation in Crohn's Disease Patients. Journal of Crohn's and Colitis. <https://doi.org/10.1093/ecco-jcc/jjy203>.
77. Weingarden AR, Vaughn BP. [Intestinal microbiota, fecal microbiota transplantation, and inflammatory bowel disease.](#) Gut Microbes. 2017;8:238–52.
78. Beck LC, Granger CL, Masi AC, Stewart CJ. [Use of omic technologies in early life gastrointestinal health and disease: From bench to bedside.](#) Expert Review of Proteomics. 2021;18:247–59.
79. Häslar R, Sheibani-Tezerji R, Sinha A, Barann M, Rehman A, Esser D, et al. [Uncoupling of mucosal gene regulation, mRNA splicing and adherent microbiota signatures in inflammatory bowel disease.](#) Gut. 2017;66:2087–97.
80. Tang MS, Bowcutt R, Leung JM, Wolff MJ, Gundra UM, Hudesman D, et al. [Integrated Analysis of Biopsies from Inflammatory Bowel Disease Patients Identifies SAA1 as a Link Between Mucosal Microbes with TH17 and TH22 Cells.](#) Inflammatory Bowel Diseases. 2017;23:1544–54.

81. Hernández-Rocha C, Borowski K, Turpin W, Filice M, Nayeri S, Raygoza Garay JA, et al. Integrative analysis of colonic biopsies from inflammatory bowel disease patients identifies an interaction between microbial bile-acid inducible gene abundance and human angiopoietin-like 4 gene expression. *Journal of Crohn's and Colitis.* 2021. <https://doi.org/10.1093/ecco-jcc/jjab096>.
82. Hu S, Vila AV, Gacesa R, Collij V, Stevens C, Fu JM, et al. Whole exome sequencing analyses reveal gene–microbiota interactions in the context of IBD. *Gut.* 2021;70:285–96.
83. Mayorgas A, Dotti I, Salas A. Microbial Metabolites, Postbiotics, and Intestinal Epithelial Function. *Molecular Nutrition & Food Research.* 2021;65:2000188.
84. Planell N, Lozano JJ, Mora-Buch R, Masamunt MC, Jimeno M, Ordás I, et al. Transcriptional analysis of the intestinal mucosa of patients with ulcerative colitis in remission reveals lasting epithelial cell alterations. *Gut.* 2013;62:967–76.
85. Leal RF, Planell N, Kajekar R, Lozano JJ, Ordás I, Dotti I, et al. Identification of inflammatory mediators in patients with Crohn's disease unresponsive to anti-TNF? therapy. *Gut.* 2015;64:233–42.
86. Massimino L, Lamparelli LA, Houshyar Y, D'Alessio S, Peyrin-Biroulet L, Vetrano S, et al. The Inflammatory Bowel Disease Transcriptome and Metatranscriptome Meta-Analysis (IBD TaMMA) framework. *Nature Computational Science.* 2021;1:511–5.
87. Knights D, Lassen KG, Xavier RJ. Advances in inflammatory bowel disease pathogenesis: Linking host genetics and the microbiome. *Gut.* 2013;62.
88. Repnik K, Potočnik U. eQTL analysis links inflammatory bowel disease associated 1q21 locus to ECM1 gene. *Journal of Applied Genetics.* 2016;57:363–72.
89. Hu S, Uniken Venema WT, Westra H-J, Vich Vila A, Barbieri R, Voskuil MD, et al. Inflammation status modulates the effect of host genetic variation on intestinal gene expression in inflammatory bowel disease. *Nature Communications.* 2021;12:1122.
90. Jung S, Liu W, Baek J, Moon JW, Ye BD, Lee H-S, et al. Expression quantitative trait loci (eQTL) mapping in korean patients with crohn's disease and identification of potential causal genes through integration with disease associations. *Frontiers in Genetics.* 2020;11.
91. Dai Y, Pei G, Zhao Z, Jia P. A convergent study of genetic variants associated with crohn's disease: Evidence from GWAS, gene expression, methylation, eQTL and TWAS. *Frontiers in Genetics.* 2019;10.
92. Ahmed I, Roy BC, Khan SA, Septer S, Umar S. Microbiome, metabolome and inflammatory bowel disease. *Microorganisms.* 2016;4:20.
93. Gallagher K, Catesson A, Griffin JL, Holmes E, Williams HRT. Metabolomic Analysis in Inflammatory Bowel Disease: A Systematic Review. *Journal of Crohn's & Colitis.* 2021;15:813–26.
94. Krassowski M, Das V, Sahu SK, Misra BB. State of the field in multi-omics research: From computational needs to data mining and sharing. *Frontiers in Genetics.* 2020;11:1598.
95. Yannakoudakis H, Cummins R. Evaluating the performance of automated text scoring systems. Denver, Colorado: Association for Computational Linguistics; 2015. p. 213223.
96. HOTELLING H. RELATIONS BETWEEN TWO SETS OF VARIATES.

- Biometrika. 1936;28:321–77.
97. Biancolillo A. **Method development in the area of multi-block analysis focused on food analysis.** PhD thesis.
 98. Wu C, Zhou F, Ren J, Li X, Jiang Y, Ma S. **A Selective Review of Multi-Level Omics Data Integration Using Variable Selection.** High-Throughput. 2019;8:4.
 99. Cavill R, Jennen D, Kleinjans J, Briedé JJ. **Transcriptomic and metabolomic data integration.** Briefings in Bioinformatics. 2016;17:891–901.
 100. Chong J, Xia J. **Computational approaches for integrative analysis of the metabolome and microbiome.** Metabolites. 2017;7:62.
 101. Rohart F, Mason EA, Matigian N, Mosbergen R, Korn O, Chen T, et al. **A molecular classification of human mesenchymal stromal cells.** PeerJ. 2016;4:e1845.
 102. Ibrahim EC, Guillemot V, Comte M, Tenenhaus A, Zendjidjian XY, Cancel A, et al. **Modeling a linkage between blood transcriptional expression and activity in brain regions to infer the phenotype of schizophrenia patients.** npj Schizophrenia. 2017;3:25.
 103. Wheeler HE, Aquino-Michaels K, Gamazon ER, Trubetskoy VV, Dolan ME, Huang RS, et al. **Poly-Omic Prediction of Complex Traits: OmicKriging.** Genetic Epidemiology. 2014;38:402–15.
 104. Yin L, Chau CKL, Sham P-C, So H-C. **Integrating Clinical Data and Imputed Transcriptome from GWAS to Uncover Complex Disease Subtypes: Applications in Psychiatry and Cardiology.** The American Journal of Human Genetics. 2019;105:1193–212.
 105. Tarazona S, Arzalluz-Luque A, Conesa A. **Undisclosed, unmet and neglected challenges in multi-omics studies.** Nature Computational Science. 2021;1–8.
 106. Tarazona S, Balzano-Nogueira L, Gómez-Cabrero D, Schmidt A, Imhof A, Hankemeier T, et al. **Harmonization of quality metrics and power calculation in multi-omic studies.** Nature Communications. 2020;11:3092.
 107. Massoni-Badosa R, Iacono G, Moutinho C, Kulis M, Palau N, Marchese D, et al. **Sampling time-dependent artifacts in single-cell genomics studies.** Genome Biology. 2020;21:112.
 108. Zhu Y, Wang L, Yin Y, Yang E. **Systematic analysis of gene expression patterns associated with postmortem interval in human tissues.** Scientific Reports. 2017;7:5435.
 109. Ferreira PG, Muñoz-Aguirre M, Reverter F, Sá Godinho CP, Sousa A, Amadoz A, et al. **The effects of death and post-mortem cold ischemia on human tissue transcriptomes.** Nature Communications. 2018;9:490.
 110. Jacob F, Monod J. **Genetic regulatory mechanisms in the synthesis of proteins.** Journal of Molecular Biology. 1961;3:318–56.
 111. Koh HWL, Fermin D, Vogel C, Choi KP, Ewing RM, Choi H. **iOomicsPASS: Network-based integration of multiomics data for predictive subnetwork discovery.** npj Systems Biology and Applications. 2019;5:1–0.
 112. Yule GU. **On the theory of correlation for any number of variables, treated by a new system of notation.** Proceedings of the Royal Society of London Series A, Containing Papers of a Mathematical and Physical Character. 1907;79:182–93.
 113. Tenenhaus A, Tenenhaus M. **Regularized Generalized Canonical Correlation Analysis.** Psychometrika. 2011;76:257–84.

114. Tenenhaus A, Philippe C, Guillemot V, Le Cao K-A, Grill J, Frouin V. **Variable selection for generalized canonical correlation analysis.** Biostatistics. 2014;15:569–83.
115. Culhane AC, Perriere G, Higgins DG. **Cross-platform comparison and visualisation of gene expression data using co-inertia analysis.** BMC Bioinformatics. 2003;4:59.
116. Vito RD, Bellio R, Trippa L, Parmigiani G. **Multi-study factor analysis.** Biometrics. 2019;75:337–46.
117. Argelaguet R, Velten B, Arnol D, Dietrich S, Zenz T, Marioni JC, et al. **Multi-Omics Factor Analysis—a framework for unsupervised integration of multi-omics data sets.** Molecular Systems Biology. 2018;14:e8124.
118. Gomez-Cabrero D, Tarazona S, Ferreirós-Vidal I, Ramirez RN, Company C, Schmidt A, et al. **STATegra, a comprehensive multi-omics dataset of B-cell differentiation in mouse.** Scientific Data. 2019;6:1–5.
119. Franzosa EA, McIver LJ, Rahnavard G, Thompson LR, Schirmer M, Weingart G, et al. **Species-level functional profiling of metagenomes and metatranscriptomes.** Nature Methods. 2018;15:962.
120. Truong DT, Franzosa EA, Tickle TL, Scholz M, Weingart G, Pasolli E, et al. **MetaPhlAn2 for enhanced metagenomic taxonomic profiling.** Nature Methods. 2015;12:902–3.
121. Segata N, Izard J, Waldron L, Gevers D, Miropolsky L, Garrett WS, et al. **Metagenomic biomarker discovery and explanation.** Genome Biology. 2011;12:R60.
122. Didier G, Valdeolivas A, Baudot A. **Identifying communities from multiplex biological networks by randomized optimization of modularity.** F1000Research. 2018;7.
123. Valdeolivas A, Tichit L, Navarro C, Perrin S, Odelin G, Levy N, et al. **Random walk with restart on multiplex and heterogeneous biological networks.** Bioinformatics (Oxford, England). 2019;35:497–505.
124. Pio-Lopez L, Valdeolivas A, Tichit L, Remy É, Baudot A. **MultiVERSE: A multiplex and multiplex-heterogeneous network embedding approach.** arXiv:200810085 [cs, q-bio]. 2021.
125. Bayes T, Price null. **An essay towards solving a problem in the doctrine of chances. By the late rev. Mr. Bayes, f. R. s.** Philosophical Transactions of the Royal Society of London. 1763;53:370–418.
126. Zhu J, Sova P, Xu Q, Dombek KM, Xu EY, Vu H, et al. **Stitching together Multiple Data Dimensions Reveals Interacting Metabolomic and Transcriptomic Networks That Modulate Cell Regulation.** PLOS Biology. 2012;10:e1001301.
127. Lock EF, Dunson DB. **Bayesian consensus clustering.** Bioinformatics. 2013;29:2610–6.
128. Cantini L, Zakeri P, Hernandez C, Naldi A, Thieffry D, Remy E, et al. **Benchmarking joint multi-omics dimensionality reduction approaches for cancer study.** bioRxiv. 2020;2020.01.14.905760.
129. Tenenhaus M, Tenenhaus A, Groenen PJF. **Regularized Generalized Canonical Correlation Analysis: A Framework for Sequential Multiblock Component Methods.** Psychometrika. 2017;82:737–77.
130. Rohart F, Gautier B, Singh A, Cao K-AL. **mixOmics: An R package for ‘omics feature selection and multiple data integration.** PLOS Computational Biology. 2017;13:e1005752.
131. Gomez-Cabrero D, Tarazona S, Ferreirós-Vidal I, Ramirez RN, Company C, Schmidt A, et al. **STATegra, a comprehensive multi-omics dataset of B-cell differentiation in mouse.** Scientific Data. 2019;6:1–5.

- C, Schmidt A, et al. **STATegra, a comprehensive multi-omics dataset of B-cell differentiation in mouse.** *Scientific Data.* 2019;6:1–5.
132. Virtanen S, Klami A, Khan S, Kaski S. **Bayesian Group Factor Analysis.** PMLR; 2012. p. 1269–77.
133. Novoa-del-Toro E-M, Mezura-Montes E, Vignes M, Magdinier F, Tichit L, Baudot A. **A Multi-Objective Genetic Algorithm to Find Active Modules in Multiplex Biological Networks.** *bioRxiv.* 2020;2020.05.25.114215.
134. Lock EF, Hoadley KA, Marron JS, Nobel AB. **JOINT AND INDIVIDUAL VARIATION EXPLAINED (JIVE) FOR INTEGRATED ANALYSIS OF MULTIPLE DATA TYPES.** *The annals of applied statistics.* 2013;7:523–42.
135. Yang Z, Michailidis G. **A non-negative matrix factorization method for detecting modules in heterogeneous omics multi-modal data.** *Bioinformatics.* 2016;32:1–8.
136. Sherry A, Henson RK. **Conducting and Interpreting Canonical Correlation Analysis in Personality Research: A User-Friendly Primer.** *Journal of Personality Assessment.* 2005;84:37–48.
137. Sherry A, Henson RK. Conducting and Interpreting Canonical Correlation Analysis in Personality Research: A User-Friendly Primer. 1981.
138. Chung R-H, Kang C-Y. **A multi-omics data simulator for complex disease studies and its application to evaluate multi-omics data analysis methods for disease classification.** *GigaScience.* 2019;8.
139. Martínez-Mira C, Conesa A, Tarazona S. **MOSim: Multi-Omics Simulation in R.** Preprint. Bioinformatics; 2018.
140. Haberman Y, Karns R, Dexheimer PJ, Schirmer M, Somekh J, Jurickova I, et al. **Ulcerative colitis mucosal transcriptomes reveal mitochondrialopathy and personalized mechanisms underlying disease severity and treatment response.** *Nature Communications.* 2019;10.
141. Patuzzi I, Baruzzo G, Losasso C, Ricci A, Di Camillo B. **metaSPAR-Sim: A 16S rRNA gene sequencing count data simulator.** *BMC Bioinformatics.* 2019;20:416.
142. Fritz A, Hofmann P, Majda S, Dahms E, Dröge J, Fiedler J, et al. **CAMISIM: Simulating metagenomes and microbial communities.** *Microbiome.* 2019;7:17.
143. Fu J, Frazee AC, Collado-Torres L, Jaffe AE, Leek JT. **Ballgown: Flexible, isoform-level differential expression analysis.** Bioconductor version: Release (3.13); 2021.
144. Frazee AC, Jaffe AE, Kirchner R, Leek JT. **Polyester: Simulate RNA-seq reads.** Bioconductor version: Release (3.13); 2021.
145. McCarthy DJ, Chen Y, Smyth GK. **Differential expression analysis of multifactor RNA-Seq experiments with respect to biological variation.** *Nucleic Acids Research.* 2012;40:4288–97.
146. De Souza HSP, Fiocchi C, Iliopoulos D. **The IBD interactome: An integrated view of aetiology, pathogenesis and therapy.** 2017;14.
147. Valles-Colomer M, Darzi Y, Vieira-Silva S, Falony G, Raes J, Joossens M. **Meta-omics in inflammatory bowel disease research: Applications, challenges, and guidelines.** *Journal of Crohn's and Colitis.* 2016;10:735–46.
148. Sudhakar P, Alsoud D, Wellens J, Verstockt S, Arnauts K, Verstockt B, et al. **Tailoring multi-omics to inflammatory bowel diseases: All for one and one for all.** *Journal of Crohn's and Colitis.* 2022;jjac027.
149. Puget S, Philippe C, Bax DA, Job B, Varlet P, Junier M-P, et al. **Mes-**

- enchymal Transition and PDGFRA Amplification/Mutation Are Key Distinct Oncogenic Events in Pediatric Diffuse Intrinsic Pontine Gliomas. PLOS ONE. 2012;7:e30313.
150. Morgan XC, Kabakchiev B, Waldron L, Tyler AD, Tickle TL, Milgrom R, et al. Associations between host gene expression, the mucosal microbiome, and clinical outcome in the pelvic pouch of patients with inflammatory bowel disease. *Genome Biology*. 2015;16:67.
151. Howell KJ, Kraiczy J, Nayak KM, Gasparetto M, Ross A, Lee C, et al. DNA Methylation and Transcription Patterns in Intestinal Epithelial Cells From Pediatric Patients With Inflammatory Bowel Diseases Differentiate Disease Subtypes and Associate With Outcome. *Gastroenterology*. 2018;154:585–98.
152. Martin M. Cutadapt removes adapter sequences from high-throughput sequencing reads. *EMBnetjournal*. 2011;17:10–2.
153. Dobin A, Davis CA, Schlesinger F, Drenkow J, Zaleski C, Jha S, et al. STAR: ultrafast universal RNA-seq aligner. *Bioinformatics* (Oxford, England). 2013;29:15–21.
154. Li B, Dewey CN. RSEM: Accurate transcript quantification from RNA-seq data with or without a reference genome. *BMC Bioinformatics*. 2011;12:323.
155. Corraliza AM, Ricart E, L'opez-García A, Carme Masamunt M, Veny M, Esteller M, et al. Differences in Peripheral and Tissue Immune Cell Populations Following Haematopoietic Stem Cell Transplantation in Crohn's Disease Patients. *Journal of Crohn's and Colitis*. <https://doi.org/10.1093/ecco-jcc/jjy203>.
156. Berry D, Ben Mahfoudh K, Wagner M, Loy A. Barcoded primers used in multiplex amplicon pyrosequencing bias amplification. *Applied and Environmental Microbiology*. 2011;77:7846–9.
157. Klindworth A, Pruesse E, Schweer T, Peplies J, Quast C, Horn M, et al. Evaluation of general 16S ribosomal RNA gene PCR primers for classical and next-generation sequencing-based diversity studies. *Nucleic Acids Research*. 2013;41:e1–1.
158. Edgar RC. UPARSE: highly accurate OTU sequences from microbial amplicon reads. *Nature Methods*. 2013;10:996–8.
159. Lagkouvardos I, Joseph D, Kapfhammer M, Giritli S, Horn M, Haller D, et al. IMNGS: A comprehensive open resource of processed 16S rRNA microbial profiles for ecology and diversity studies. *Scientific Reports*. 2016;6.
160. Callahan BJ, McMurdie PJ, Rosen MJ, Han AW, Johnson AJA, Holmes SP. DADA2: High-resolution sample inference from Illumina amplicon data. *Nature Methods*. 2016;13:581–3.
161. Meng C, Kuster B, Culhane AC, Gholami AM. A multivariate approach to the integration of multi-omics datasets. *BMC Bioinformatics*. 2014;15:162.
162. Planell N, Lagani V, Sebastian-Leon P, van der Kloet F, Ewing E, Karathanasis N, et al. STATEGRA: Multi-omics data integration – a conceptual scheme with a bioinformatics pipeline. *Frontiers in Genetics*. 2021;12.
163. Jordan C. Essai sur la géométrie à n dimensions. *Bulletin de la Société Mathématique de France*. 1875;3:103–74.
164. HOTELLING H. RELATIONS BETWEEN TWO SETS OF VARIATES. *Biometrika*. 1936;28:321–77.
165. Tenenhaus M. Component-based Structural Equation Modelling. *Total Quality Management & Business Excellence*. 2008;19:871–86.
166. Tenenhaus M, Hanafi M. A Bridge Between PLS Path Modeling and Multi-Block Data Analysis. In: Esposito Vinzi V, Chin WW, Henseler J, Wang H,

- editors. *Handbook of Partial Least Squares*. Berlin, Heidelberg: Springer Berlin Heidelberg; 2010. p. 99–123.
167. Tenenhaus A, Tenenhaus M. *Regularized generalized canonical correlation analysis for multiblock or multigroup data analysis*. European Journal of Operational Research. 2014;238:391–403.
168. Tenenhaus A, Philippe C, Frouin V. *Kernel Generalized Canonical Correlation Analysis*. Computational Statistics & Data Analysis. 2015;90:114–31.
169. Gloaguen A, Philippe C, Frouin V, Gennari G, Dehaene-Lambertz G, Le Brusquet L, et al. Multiway generalized canonical correlation analysis. *Bio-statistics*. 2020. <https://doi.org/10.1093/biostatistics/kxaa010>.
170. Schäfer J, Strimmer K. *A Shrinkage Approach to Large-Scale Covariance Matrix Estimation and Implications for Functional Genomics*. Statistical Applications in Genetics and Molecular Biology. 2005;4.
171. Horst P. *Relations among m sets of measures*. Psychometrika. 1961;26:129–49.
172. KETTENRING JR. *Canonical analysis of several sets of variables*. Biometrika. 1971;58:433–51.
173. Van de Geer JP. *Linear relations among k sets of variables*. Psychometrika. 1984;49:79–94.
174. Ritchie MEM, Phipson B, Wu D, Hu Y, Law CWC, Shi W, et al. *Limma powers differential expression analyses for RNA-sequencing and microarray studies*. Nucleic acids research. 2015;43:e47.
175. Law CW, Chen Y, Shi W, Smyth GK. *Voom: Precision weights unlock linear model analysis tools for RNA-seq read counts*. Genome Biology. 2014;15:R29.
176. Law CW, Alhamdoosh M, Su S, Dong X, Tian L, Smyth GK, et al. *RNA-seq analysis is easy as 1-2-3 with limma, Glimma and edgeR*. F1000Research. 2018;5.
177. Yoav Benjamini, Yosef Hochberg. *Controlling the False Discovery Rate: A Practical and Powerful Approach to Multiple Testing*. Journal of the Royal Statistical Society Series B (Methodological). 57.
178. Wu T, Hu E, Xu S, Chen M, Guo P, Dai Z, et al. *clusterProfiler 4.0: A universal enrichment tool for interpreting omics data*. The Innovation. 2021;2:100141.
179. Richter FC, Friedrich M, Pohin M, Alsaleh G, Guschina I, Wideman SK, et al. *Cell-extrinsic autophagy in mature adipocytes regulates anti-inflammatory response to intestinal tissue injury through lipid mobilization*. 2021;2021.10.25.465200.
180. Subramanian A, Tamayo P, Mootha VK, Mukherjee S, Ebert BL, Gillette MA, et al. *Gene set enrichment analysis: A knowledge-based approach for interpreting genome-wide expression profiles*. Proceedings of the National Academy of Sciences. 2005;102:15545–50.
181. Protiva P, Pendyala S, Nelson C, Augenlicht LH, Lipkin M, Holt PR. *Calcium and 1,25-dihydroxyvitamin D3 modulate genes of immune and inflammatory pathways in the human colon: A human crossover trial*. The American Journal of Clinical Nutrition. 2016;103:1224–31.
182. Korotkevich G, Sukhov V, Budin N, Shpak B, Artyomov MN, Sergushichev A. Fast gene set enrichment analysis. 2021. <https://doi.org/https://doi.org/10.1101/060012>.
183. Fabregat A, Sidiropoulos K, Garapati P, Gillespie M, Hausmann K, Haw R,

- et al. **The reactome pathway knowledgebase**. Nucleic Acids Research. 2016;44.
184. Hänelmann S, Castelo R, Guinney J. **GSVA: Gene set variation analysis for microarray and RNA-seq data**. BMC Bioinformatics. 2013;14:7.
185. Escudero-Hernández C, Beelen Granlund A van, Bruland T, Sandvik AK, Koch S, Østvik AE, et al. **Transcriptomic Profiling of Collagenous Colitis Identifies Hallmarks of Nondestructive Inflammatory Bowel Disease**. Cellular and Molecular Gastroenterology and Hepatology. 2021;12:665–87.
186. Anderson MJ. **A new method for non-parametric multivariate analysis of variance**. Austral Ecology. 2001;26:32–46.
187. Warton DI, Wright ST, Wang Y. **Distance-based multivariate analyses confound location and dispersion effects**. Methods in Ecology and Evolution. 2012;3:89–101.
188. Goeman JJ, van de Geer SA, van Houwelingen HC. **Testing against a high dimensional alternative**. Journal of the Royal Statistical Society Series B (Statistical Methodology). 2006;68:477–93.
189. Oksanen J, Blanchet FG, Friendly M, Kindt R, Legendre P, McGlinn D, et al. **Vegan: Community ecology package**. 2020.
190. Langfelder P, Horvath S. **WGCNA: An r package for weighted correlation network analysis**. BMC Bioinformatics. 2008;9:559.
191. Filzmoser P, Vierl R. **Testing hypotheses with fuzzy data: The fuzzy p-value**. Metrika. 2004;59:21–9.
192. Dubois D, Prade H. [Proceedings 1993] second IEEE international conference on fuzzy systems. 1993. p. 1059–1068 vol.2.
193. Revilla Sancho L, Lozano J-J, Salas A. **experDesign: stratifying samples into batches with minimal bias**. Journal of Open Source Software. 2021;6:3358.
194. Robin X, Turck N, Hainard A, Tiberti N, Lisacek F, Sanchez J-C, et al. **pROC: An open-source package for r and s+ to analyze and compare ROC curves**. BMC Bioinformatics. 2011;12:77.
195. Wickham H. **Advanced r**. Second Edition. Boca Raton: Chapman & Hall; 2019.
196. Greenland S, Brumback B. **An overview of relations among causal modelling methods**. International Journal of Epidemiology. 2002;31:1030–7.
197. Revilla L, Mayorgas A, Corraliza AM, Masamunt MC, Metwaly A, Haller D, et al. **Multi-omic modelling of inflammatory bowel disease with regularized canonical correlation analysis**. PLOS ONE. 2021;16:e0246367.
198. Nearing JT, Douglas GM, Hayes MG, MacDonald J, Desai DK, Allward N, et al. **Microbiome differential abundance methods produce different results across 38 datasets**. Nature Communications. 2022;13:342.
199. Louca S, Doebeli M, Parfrey LW. **Correcting for 16S rRNA gene copy numbers in microbiome surveys remains an unsolved problem**. Microbiome. 2018;6:41.
200. Nadalian B, Yadegar A, Houra H, Olfatifar M, Shahrokh S, Asadzadeh Aghdaei H, et al. **Prevalence of the pathobiont adherent-invasive Escherichia coli and inflammatory bowel disease: a systematic review and meta-analysis**. Journal of Gastroenterology and Hepatology. 2021;36:852–63.
201. Martínez-Mira C, Conesa A, Tarazona S. **MOSim: Multi-Omics Simulation in R**. 2018.
202. Cantini L, Zakeri P, Hernandez C, Naldi A, Thieffry D, Remy E, et al. **Benchmarking joint multi-omics dimensionality reduction approaches for the study of cancer**. Nature Communications. 2021;12:124.

203. Human Microbiome Project Consortium BA, Nelson KE, Pop M, Creasy HH, Giglio MG, Huttenhower C, et al. [A framework for human microbiome research](#). *Nature*. 2012;486:21521.
204. Ugidos M, Tarazona S, Prats-Montalbán JM, Ferrer A, Conesa A. MultiBaC: A strategy to remove batch effects between different omic data types: *Statistical Methods in Medical Research*. 2020. <https://doi.org/10.1177/0962280220907365>.
205. Cantini L, Zakeri P, Hernandez C, Naldi A, Thieffry D, Remy E, et al. [Benchmarking joint multi-omics dimensionality reduction approaches for cancer study](#). *bioRxiv*. 2020;2020.01.14.905760.
206. Holmes E, Li JV, Marchesi JR, Nicholson JK. [Gut Microbiota Composition and Activity in Relation to Host Metabolic Phenotype and Disease Risk](#). *Cell Metabolism*. 2012;16:559–64.
207. Stappenbeck TS, Hooper LV, Gordon JI. [Developmental regulation of intestinal angiogenesis by indigenous microbes via Paneth cells](#). *Proceedings of the National Academy of Sciences of the United States of America*. 2002;99:15451–5.
208. Brand EC, Klaassen MAY, Gacesa R, Vich Vila A, Ghosh H, Zoete MR de, et al. [Healthy Cotwins Share Gut Microbiome Signatures With Their Inflammatory Bowel Disease Twins and Unrelated Patients](#). *Gastroenterology*. 2021;160:1970–85.
209. Susin A, Wang Y, Lê Cao K-A, Calle ML. [Variable selection in microbiome compositional data analysis](#). *NAR Genomics and Bioinformatics*. 2020;2:lqaa029.
210. Yan L, Ma C, Wang D, Hu Q, Qin M, Conroy JM, et al. [OSAT: A tool for sample-to-batch allocations in genomics experiments](#). *BMC Genomics*. 2012;13:689.
211. Papenberg M, Klau GW. Using antoclustering to partition data sets into equivalent parts. *Psychological Methods*. 2020. <https://doi.org/10.1037/met0000301>.
212. Sinke L, Cats D, Heijmans BT. Omixer: Multivariate and reproducible sample randomization to proactively counter batch effects in omics studies. *Bioinformatics*. 2021. <https://doi.org/10.1093/bioinformatics/btab159>.
213. Haberman Y, Tickle TL, Dexheimer PJ, Kim M-O, Tang D, Karns R, et al. [Pediatric Crohn disease patients exhibit specific ileal transcriptome and microbiome signature](#). *The Journal of Clinical Investigation*. 2014;124:3617–33.
214. Meng C, Kuster B, Culhane AC, Gholami AM. [A multivariate approach to the integration of multi-omics datasets](#). *BMC Bioinformatics*. 2014;15:162.
215. Jiang D, Armour CR, Hu C, Mei M, Tian C, Sharpton TJ, et al. [Microbiome multi-omics network analysis: Statistical considerations, limitations, and opportunities](#). *Frontiers in Genetics*. 2019;10.
216. Ungar B, Yavzori M, Fudim E, Picard O, Kopylov U, Eliakim R, et al. Host transcriptome signatures in human faecal-washes predict histological remission in patients with IBD. *Gut*. 2022. <https://doi.org/10.1136/gutjnl-2021-325516>.
217. Zhang X, Li L, Butcher J, Stintzi A, Figgeys D. [Advancing functional and translational microbiome research using meta-omics approaches](#). *Microbiome*. 2019;7:154.
218. Collij V, Klaassen MAY, Weersma RK, Vila AV. [Gut microbiota in inflammatory bowel diseases: moving from basic science to clinical applications](#). *Human Genetics*. 2021;140:703–8.

219. Parkhomenko E, Tritchler D, Beyene J. **Sparse Canonical Correlation Analysis with Application to Genomic Data Integration.** Statistical Applications in Genetics and Molecular Biology. 2009;8.
220. Waaijenborg S, Hamer PCV de W, Zwinderman AH. **Quantifying the Association between Gene Expressions and DNA-Markers by Penalized Canonical Correlation Analysis.** Statistical Applications in Genetics and Molecular Biology. 2008;7.
221. Witten DM, Tibshirani RJ. **Extensions of sparse canonical correlation analysis with applications to genomic data.** Statistical Applications in Genetics and Molecular Biology. 2009;8:127.
222. Lê Cao K-A, Martin PG, Robert-Granié C, Besse P. **Sparse canonical methods for biological data integration: Application to a cross-platform study.** BMC Bioinformatics. 2009;10:34.
223. Hwang H. **Regularized Generalized Structured Component Analysis.** Psychometrika. 2009;74:517–30.
224. Soneson C, Lilljebjörn H, Fioretos T, Fontes M. **Integrative analysis of gene expression and copy number alterations using canonical correlation analysis.** BMC Bioinformatics. 2010;11:191.
225. Zhang S, Li Q, Liu J, Zhou XJ. **A novel computational framework for simultaneous integration of multiple types of genomic data to identify microRNA-gene regulatory modules.** Bioinformatics. 2011;27:i401–9.
226. Lee W, Lee D, Lee Y, Pawitan Y. **Sparse Canonical Covariance Analysis for High-throughput Data.** Statistical Applications in Genetics and Molecular Biology. 2011;10.
227. Abdi H, Williams LJ, Valentin D, Bennani-Dosse M. **STATIS and DISTATIS: optimum multitable principal component analysis and three way metric multidimensional scaling.** WIREs Computational Statistics. 2012;4:124–67.
228. Zhang S, Liu C-C, Li W, Shen H, Laird PW, Zhou XJ. **Discovery of multidimensional modules by integrative analysis of cancer genomic data.** Nucleic Acids Research. 2012;40:9379–91.
229. Li W, Zhang S, Liu C-C, Zhou XJ. **Identifying multi-layer gene regulatory modules from multi-dimensional genomic data.** Bioinformatics. 2012;28:2458–66.
230. Abdi H, Williams LJ, Valentin D. **Multiple factor analysis: principal component analysis for multitable and multiblock data sets.** WIREs Computational Statistics. 2013;5:149–79.
231. Schlau D, Paulson JN, Young A, Glass K, Quackenbush J. **Estimating gene regulatory networks with pandaR.** Bioinformatics. 2017;33:2232–4.
232. Ray P, Zheng L, Lucas J, Carin L. **Bayesian joint analysis of heterogeneous genomics data.** Bioinformatics. 2014;30:1370–6.
233. Bunte K, Leppäaho E, Saarinen I, Kaski S. **Sparse group factor analysis for biclustering of multiple data sources.** Bioinformatics. 2016;32:2457–63.
234. Chen M, Gao C, Ren Z, Zhou HH. **Sparse CCA via precision adjusted iterative thresholding.** arXiv:13116186 [math, stat]. 2013.
235. Leppäaho E, Ammad-ud-din M, Kaski S. **GFA: Exploratory analysis of multiple data sources with group factor analysis.** Journal of Machine Learning Research. 2017;18:1–5.
236. Klami A, Bouchard G, Tripathi A. **Group-sparse embeddings in collective matrix factorization.** arXiv:13125921 [cs, stat]. 2014.
237. Meng C, Basunia A, Peters B, Gholami AM, Kuster B, Culhane AC.

- MOGSA: integrative single sample gene-set analysis of multiple omics data. 2018.
238. Yang Z, Michailidis G. A non-negative matrix factorization method for detecting modules in heterogeneous omics multi-modal data. *Bioinformatics*. 2016;32:1–8.
239. Zhao S, Gao C, Mukherjee S, Engelhardt BE. Bayesian group latent factor analysis with structured sparsity. arXiv:14112698 [q-bio, stat]. 2015.
240. Voillet V, Besse P, Liaubet L, San Cristobal M, González I. Handling missing rows in multi-omics data integration: Multiple imputation in multiple factor analysis framework. *BMC Bioinformatics*. 2016;17:402.
241. Beaton D, Dunlop J, Abdi H, Alzheimer's Disease Neuroimaging Initiative. Partial least squares correspondence analysis: A framework to simultaneously analyze behavioral and genetic data. *Psychological Methods*. 2016;21:621–51.
242. Singh A, Shannon CP, Gautier B, Rohart F, Vacher M, Tebbutt SJ, et al. DIABLO: An integrative approach for identifying key molecular drivers from multi-omics assays. *Bioinformatics*. 2019;35:3055–62.
243. Yoon G, Carroll RJ, Gaynanova I. Sparse semiparametric canonical correlation analysis for data of mixed types. arXiv:180705274 [stat]. 2019.
244. Gaynanova I, Li G. Structural learning and integrative decomposition of multi-view data. arXiv:170706573 [stat]. 2017.
245. Madrigal P. FCCAC: Functional canonical correlation analysis to evaluate covariance between nucleic acid sequencing datasets. *Bioinformatics*. 2017;33:746–8.
246. Yoshida K, Yoshimoto J, Doya K. Sparse kernel canonical correlation analysis for discovery of nonlinear interactions in high-dimensional data. *BMC Bioinformatics*. 2017;18:108.
247. Kawaguchi A, Yamashita F. Supervised multiblock sparse multivariable analysis with application to multimodal brain imaging genetics. *Biostatistics*. 2017;18:651–65.
248. Feng Q, Jiang M, Hannig J, Marron JS. Angle-based joint and individual variation explained. arXiv:170402060 [stat]. 2018.
249. Argelaguet R, Arnol D, Bredikhin D, Deloro Y, Velten B, Marioni JC, et al. MOFA+: A statistical framework for comprehensive integration of multi-modal single-cell data. *Genome Biology*. 2020;21:111.
250. Brown BC, Bray NL, Pachter L. Expression reflects population structure. 2018. <https://doi.org/10.1101/364448>.
251. Zhang Y, Gaynanova I. Joint association and classification analysis of multi-view data. arXiv:181108511 [cs, stat]. 2020.
252. Tang TM, Allen GI. Integrated principal components analysis. arXiv:181000832 [stat]. 2021.
253. Min EJ, Safo SE, Long Q. Penalized co-inertia analysis with applications to -omics data. *Bioinformatics* (Oxford, England). 2019;35:1018–25.
254. Safo SE, Li S, Long Q. Integrative analysis of transcriptomic and metabolomic data via sparse canonical correlation analysis with incorporation of biological information. *Biometrics*. 2018;74:300–12.
255. Min W, Liu J, Zhang S. Sparse weighted canonical correlation analysis. arXiv:171004792 [cs, stat]. 2017.
256. Bouhaddani S el, Uh H-W, Jongbloed G, Hayward C, Klarić L, Kielbasa SM, et al. Integrating omics datasets with the OmicsPLS package. *BMC Bioinformatics*. 2018;19:371.

257. Pimentel H, Zhiyue H, Huang H. [Biclustering by sparse canonical correlation analysis](#). 2018;6:11.
258. Kim Y, Bismeyer T, Zwart W, Wessels LFA, Vis DJ. [Genomic data integration by WON-PARAFAC identifies interpretable factors for predicting drug-sensitivity in vivo](#). Nature Communications. 2019;10:5034.
259. Lock EF, Park JY, Hoadley KA. [Bidimensional linked matrix factorization for pan-omics pan-cancer analysis](#). arXiv:200202601 [cs, q-bio, stat]. 2020.
260. Ronen J, Hayat S, Akalin A. [Evaluation of colorectal cancer subtypes and cell lines using deep learning](#). Life Science Alliance. 2019;2.
261. Shi WJ, Zhuang Y, Russell PH, Hobbs BD, Parker MM, Castaldi PJ, et al. [Unsupervised discovery of phenotype-specific multi-omics networks](#). Bioinformatics. 2019;35:4336–43.
262. Csala A, Zwinderman AH, Hof MH. [Multiset sparse partial least squares path modeling for high dimensional omics data analysis](#). BMC Bioinformatics. 2020;21:9.
263. Fan Z, Zhou Y, Ressom HW. [MOTA: Network-Based Multi-Omic Data Integration for Biomarker Discovery](#). Metabolites. 2020;10:144.
264. Shu H, Wang X, Zhu H. [D-CCA: A decomposition-based canonical correlation analysis for high-dimensional datasets](#). Journal of the American Statistical Association. 2020;115:292–306.
265. Hawinkel S, Bijnens L, Cao K-AL, Thas O. [Model-based joint visualization of multiple compositional omics datasets](#). NAR Genomics and Bioinformatics. 2020;2.
266. Gundersen G, Dumitrescu B, Ash JT, Engelhardt BE. [Uncertainty in Artificial Intelligence](#). PMLR; 2020. p. 945–55.
267. Velten B, Braunger JM, Arnol D, Argelaguet R, Stegle O. [Identifying temporal and spatial patterns of variation from multi-modal data using MEFISTO](#). bioRxiv. 2020;2020.11.03.366674.

Appendix A

Online resources

Some links that I found useful on the thesis and could be useful if you are interested on the multi-omics field.

- **Awesome multi-omics** <https://github.com/mikelove/awesome-multi-omics> : An online repository of references to multi-omics methods. Reproduced here with their references ¹:

Table A.1: Integration methods available and their references.

Method	Publication
SCCA	[219]
PCCA	[220]
PMA	[221]
sPLS	[222]
gesca	[223]
Regularized dual CCA	[224]
RGCCA	[113]
SNMNMF	[225]
scca	[226]
STATIS	[227]
joint NMF	[228]
sMBPLS	[229]
Bayesian group factor analysis	[132]
RIMBANET	[126]
FactoMineR	[230]
JIVE	[134]
pandaR	[231]
omicade4	[161]
STATegRa	[162]
Joint factor model	[232]

¹Consulted on 2021/11/10 from <https://github.com/mikelove/awesome-multi-omics>

Method	Publication
GFAsparse	[233]
Sparse CCA	[234]
CCAGFA	[235]
CMF	[236]
MOGSA	[237]
iNMF	[238]
BASS	[239]
imputeMFA	[240]
PLSCA	[241]
mixOmics	[242]
mixedCCA	[243]
SLIDE	[244]
fCCAC	[245]
TSKCCA	[246]
SMSMA	[247]
AJIVE	[248]
MOFA	[249]
PCA+CCA	[250]
JACA	[251]
iPCA	[252]
pCIA	[253]
sSCCA	[254]
SWCCA	[255]
OmicsPLS	[256]
SCCA-BC	[257]
WON-PARAFAC	[258]
BIDIFAC	[259]
maui	[260]
SmCCNet	[261]
msPLS	[262]
MOTA	[263]
D-CCA	[264]
COMBI	[265]
DPCCA	[266]
MEFISTO	[267]
MultiPower	[106]

- [Bookdown](#): The book about how to write this type of books.
- [Bioconductor](#): The project about bioinformatics on R mostly related to sequencing technologies.
- [CRAN](#): The main archive of R extensions/packages for R.
- [GitHub](#): Company which allows to freely host remote [git](#) repositories of many projects, including some used or developed on this thesis.

Appendix B

Software

Along the years of this thesis several pieces of software have been generated as well as packages. Here they are listed for easier retrieval. They are listed on two ways, one with a brief explanation and another one ordered by what software piece is used on each analysis.

B.1 STAR

The parameters and options used with STAR are:

```
STAR \
--outSAMtype BAM SortedByCoordinate \
--outFilterIntronMotifs RemoveNoncanonical \
--outSAMattributes All \
--outReadsUnmapped Fastx \
--outSAMstrandField intronMotif \
--outFilterScoreMinOverLread 0.5 \
--outFilterMatchNminOverLread 0.5 \
--outFilterType BySJout \
--alignSJoverhangMin 8 \
--alignSJDBoverhangMin 1 \
--outFilterMismatchNmax 999 \
--outFilterMismatchNoverLmax 0.04 \
--genomeDir "$genome/STAR" \
--limitBAMsortRAM 10000000000 \
--runMode alignReads \
--genomeLoad NoSharedMemory \
--quantMode TranscriptomeSAM \
--outFileNamePrefix $output \
--runThreadN "$threads" \
--readFilesCommand zcat \
--readFilesIn "$file1" "$file2"
```

B.2 RSEM

Code used for RSEM

```
rsem-calculate-expression \
--quiet \
--paired-end \
-p "$threads" \
--estimate-rspd \
--append-names \
--no-bam-output \
--bam "$rseminp" "$genome/RSEM/RSEM" "$rsem"
```

B.3 Listed

An improved/tested version of [RGCCA](#), some modifications on the internal functions to ease the maintenance as well as adding tests and sometimes improving the documentation. Also modified so that it is possible to provide a vector of models so that the model of the first dimension is not the same as the model on the second dimension (not sure if mathematically speaking makes sense but from a biological one I think it might be interesting to have it).

Designed to be used with RGCCA I wrote the package [inteRmodel](#) to ease the bootstrapping and model selection.

A package to design batches to avoid batch effect [experDesign](#) and its website on [GitHub](#).

Explore the effects of the hyperparameters on RGCCA on the provided dataset of [gliomaData](#) (Originally provided [here](#)) there is this repository [sgcca_hyperparameters](#).

We used a pouchitis cohort published in this [article](#)[150] that was used to compare how performs our method in other's dataset. The code used can be found in [this repository](#).

Some functions used to explore the TRIM dataset ended up in the [integration](#) package. This include functions for correlation, network analysis, enrichment, normalization of metadata...

I developed a package to analyze sets and fuzzy sets [BaseSet](#) (based on what I learned from a previous iteration of the [package](#)). This package was meant to be used with the probabilities that arise from bootstrapping the models. However, due to the long times of calculation that it would require it was not used.

To analyze the BARCELONA cohort (also named antiTNF) a [different repository](#) was created to analyze the data using the previously developed packages.

B.4 By project/publication

All code of the analysis of the publications is available (in his messed state and complicated history) and a brief description as to why they were used:

Multi-omic modelling of inflammatory bowel disease with regularized canonical correlation analysis:

- [TRIM](#): Mangle with the sample, dataset, explore several methods...
- [Puget's](#): Explore the effects of the hyperparameters on RGCCA on the provided dataset.
- [inteRmodel](#): Package for easy repeating the methodology developed on TRIM.
- [Morgan's](#): Work with the pouchitis cohort used in this article.
- [Häsler's](#): Work with the UC/CD dataset used in this article.
- [integration](#): Package with functions that I wrote or used on different parts of exploring the TRIM dataset ended up here.

BaseSet:

- [BaseSet](#): Fuzzy logic implementation, available on [rOpenSci](#) too and its documentation website .

experDesign:

- [experDesign](#): Help design experiments in batches. It has a documentation website too.

BARCELONA:

- [BARCELONA](#): Code to analyze the BARCELONA's dataset

Validation:

- [Howell's](#): Work with Howell's 2018 dataset.
- [Cristian's](#): Work with Cristian's 2020 dataset.

Appendix C

Articles

Articles related to this project published during the thesis.

C.1 Multi-omic modelling of inflammatory bowel disease with regularized canonical correlation analysis

[Available online](#)

RESEARCH ARTICLE

Multi-omic modelling of inflammatory bowel disease with regularized canonical correlation analysis

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Data Availability Statement: Gioma data available from <https://biodev.ceia.fr/gcoca/> RNA-seq data from CD dataset available at <https://www.ncbi.nlm.nih.gov/geo/query/acc.cgi?acc=GSE139179> Microbiome data from CD dataset available at <https://www.ncbi.nlm.nih.gov/geo/query/acc.cgi?acc=GSE139680> data from pouchitis dataset available at <https://www.ncbi.nlm.nih.gov/geo/query/acc.cgi?acc=GSE65270> Analysis code of our HSCT CD dataset available at: <https://github.com/ltrs/TRIM> repository. Parameter studies performed at https://github.com/ltrs/sgcca_hyperparameters.

Abstract

Background

Personalized medicine requires finding relationships between variables that influence a patient's phenotype and predicting an outcome. Sparse generalized canonical correlation analysis identifies relationships between different groups of variables. This method requires establishing a model of the expected interaction between those variables. Describing these interactions is challenging when the relationship is unknown or when there is no pre-established hypothesis. Thus, our aim was to develop a method to find the relationships between microbiome and host transcriptome data and the relevant clinical variables in a complex disease, such as Crohn's disease.

Results

We present here a method to identify interactions based on canonical correlation analysis. We show that the model is the most important factor to identify relationships between blocks using a dataset of Crohn's disease patients with longitudinal sampling. First the analysis was tested in two previously published datasets: a glioma and a Crohn's disease and ulcerative colitis dataset where we describe how to select the optimum parameters. Using such parameters, we analyzed our Crohn's disease data set. We selected the model with the highest inner average variance explained to identify relationships between transcriptome, gut microbiome and clinically relevant variables. Adding the clinically relevant variables improved the average variance explained by the model compared to multiple co-inertia analysis.

Conclusions

The methodology described herein provides a general framework for identifying interactions between sets of omic data and clinically relevant variables. Following this method, we found

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CD/UC dataset analysis available at: <https://github.com/lirs/Uncoupling> Pouchitis dataset analysis available at: <https://github.com/lirs/pouchitis> Helper package required for the analysis available at <https://github.com/lirs/integration-helper>. Package with the methodology: Project name: interRmodel Project home page: <https://lirs.github.io/inteRmodel/> Operating system: Platform independent Programming language: R License: MIT.

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Competing interests: We confirm that the following competing interests' statement does not alter our adherence to PLOS ONE policies on sharing data and materials: I have read the journal's policy and the authors of this manuscript have the following competing interests: JP has received consulting fees from AbbVie, Arena Pharmaceuticals, Boehringer Ingelheim, Celgene, Celltrion, Ferring, Genentech, Janssen, Merck, Sharp & Dohme (MSD), Opillan, Pfizer, Progenity, Robarts, Roche, Takeda, Theravance, and TiGenix; speaker's fees from AbbVie, Ferring, Janssen, MSD, Shire Pharmaceuticals, and Takeda; and research funding from AbbVie and MSD. AS reports research grants from Roche, Genentech, Boehringer Ingelheim and AbbVie, lecture fees from Roche, Boehringer Ingelheim and Pfizer, and consultancy fees from Genentech and GSK.

genes and microorganisms that were related to each other independently of the model, while others were specific to the model used. Thus, model selection proved crucial to finding the existing relationships in multi-omics datasets.

Introduction

The creation of datasets from different high-throughput sequencing technologies on the same samples provides an opportunity to identify relationships between datasets and improve our understanding of diseases. This approach has been used in several diseases, such as cancer, inflammatory bowel disease (IBD) and pouchitis, among others [1–3].

IBD is comprised of Crohn's disease (CD) and ulcerative colitis (UC). Around 4.2 million individuals suffer from IBD in Europe and North America combined [4]. The chronic inflammatory response observed suggests an interaction between host genetic factors and the intestinal microbiota. Several studies support the concept that CD arises from an exacerbated immune response against commensal gut microorganisms in genetically predisposed individuals. Nonetheless, the disease might result from imbalanced microbial composition, leading to dysbiosis [5, 6].

Understanding the contribution of the gut microbiota to CD pathogenesis and maintenance of the disease is an ongoing field of research [7–9]. These alterations could be shaped by a genetic predisposition and environmental factors (i.e., bacterial or viral infection, diet, usage of antibiotic, or the socioeconomic status) [10]. On the other hand, pouchitis refers to the inflammation of the ileal pouch, an artificial rectum surgically created out of ileal gut tissue in patients who have undergone a colectomy. One possible underlying cause of pouchitis might also be the an imbalance in the gut microbiome [11]. However, the cause-effect relation between dysbiosis and intestinal inflammatory disease remains unclear [12–14].

The most common method for analyzing the relationship between microorganisms and the gut mucosa is to sequence both the 16S rRNA gene of the microbiome and the patient's transcriptome, respectively. Gut microbial DNA can be sequenced from feces or intestinal tissue, while human RNA is isolated from endoscopic biopsies or surgical samples. In some cases, patients are followed up for long periods and longitudinal samples can be obtained [15]. Multivariate methods are used to integrate DNA and RNA data, and therefore can identify relationships between the intestinal microbiome and the gut epithelium [8, 14, 16, 17]. Correlations, which are multivariate, are the predominant method used to find relationships between two omics datasets [7, 17–19]. A recent study revealed more significant correlations between host RNA and microbial DNA in samples from healthy controls than in patients with IBD, and suggests an "uncoupling" or breakup of these "homeostatic" correlations in diseased subjects [7]. Although their analysis used correlations, as well as univariate methods, these method do not consider confounders such as age, diet or sample localization in the gut, which could lead to false conclusions [20, 21].

Other multivariate methods provide frameworks with an unlimited number of variables involved [22, 23]. These methods summarize the variability of the datasets and select features in order to obtain loading factors for a new coordinate system where samples are represented. They summarize the largest amount of variability found among the samples' variables [24]. Those multivariate methods are capable of summarizing several variables from the same sample. Some multivariate methods work when variables are grouped in a block. Multi-block methods allow to analyze variables obtained from different technical origins [25–29]. These

multi-block methods assume the existence of relationships between variables of the different blocks.

An example of a multi-block method is the regularized generalized canonical correlation analysis (RGCCA) which enables reducing the dimensions of an arbitrary number of blocks for data derived from the same sample [30–32]. RGCCA has already been used in the context of IBD with RNA-seq and 16S rRNA data [16]. However, it was used to select human genes and microorganism related to the inflammation predictors DUOX2 and APOA1. To our knowledge, a concrete description of the relationship between the gut's mucosal host transcriptome and microbiome in CD using RGCCA has not been performed.

In this study, we evaluate the effect of the parameters of RGCCA on the canonical components and we identify a strategy of analysis that better explains two previously published datasets. We then used this method, as well as multiple co-inertia analysis (MCIA), to compare two datasets, our hematopoietic stem cell transplant CD dataset and an online available pouchitis dataset in order to identify interactions between microorganisms and the host transcriptome of the gut epithelium [33]. Overall, we believe that our approach constitutes an innovative method for identifying multiple relationships present in multi-omics datasets and their most relevant variables. Identifying those relevant variables will lead to discover the cross-talk between microorganisms and the host and enhance our knowledge of the inflammatory bowel disease.

Methods

Patients and biopsies processing

Samples from the CD dataset included in this study were from a cohort of patients with severe refractory CD undergoing hematopoietic stem cell transplant (HSCT). Patients were treated in the Department of Gastroenterology (Hospital Clinic de Barcelona–Spain–). The protocol was approved by the Catalan Transplantation Organization and by the Institutional Ethics Committee of the Hospital Clinic de Barcelona (Study Number 2012/7244). All patients provided written consent following extensive counselling. Colonic and ileal biopsies were obtained at several time points during ileocolonoscopy. Patients were followed-up for 4 years and biopsies were collected every six or twelve months after HSCT. Samples were obtained when possible from both uninvolved and involved areas. In addition, biopsies were taken from the ileum and colon regions of 19 non-IBD controls consisting of individuals with no history of IBD and who presented no significant pathological findings following endoscopic examination for colon cancer surveillance (Hospital Universitari Mútua de Terrassa–Spain–). The protocol was approved by the Institutional Ethics Committee of the Hospital Universitari Mútua de Terrassa (Study Number NA1651). At least one biopsy was collected and fresh-frozen at -80°C for microbial DNA extraction. The remaining biopsies were placed in RNAlater RNA Stabilization Reagent (Qiagen, Hilde, Germany) and stored at -80°C until total RNA extraction.

Mucosal transcriptome

Total RNA from mucosal samples (HSCT CD cohort) was isolated using the RNeasy kit (Qiagen, Hilde, Germany). RNA sequencing libraries were prepared for paired-end sequencing using HighSeq-4000 platform. Later, cutadapt (version 1.7.1) was used for quality filtering and the libraries were mapped against the human reference genome using the STAR aligner (2.5.2a) with Ensembl annotation (release GRCh38.10). Read counts per gene were obtained with RSEM (version 1.2.31) as previously described [15]. Analysis was performed using R (version 3.6.1) and Bioconductor (Version 3.10) on Ubuntu 18.04. The host transcriptome was visually inspected for batch effects in PCA. Outliers and the top 10% genes using the coefficient

of variation were removed (20593, with remaining 37685 genes). Data was normalized using the trimmed mean of M-values and log transformed into counts per millions using edgeR (version 3.28).

Microbial DNA extraction from mucosal samples

Biopsies from the HSCT CD cohort were resuspended in 180 µl TET (TrisHCl 0.02M, EDTA 0.002M, Triton 1X) buffer and 20mg/ml lysozyme (Carl Roth, Quimivita, S.A.). Samples were incubated for 1h at 37°C and vortexed with 25 µl Proteinase K before incubating at 56°C for 3h. Buffer B3 (NucleoSpin Tissue Kit–Macherey-Nagel) was added followed by a heat treatment for 10 min at 70°C. After adding 100% ethanol, samples were centrifuged at 11000 x g for 1 min. Two washing steps were performed before eluting DNA. Concentrations and purity were checked using NanoDrop One (Thermo Fisher Scientific). Samples were immediately used or placed at -20°C for long-term storage.

High throughput 16S ribosomal RNA (rRNA) gene sequencing

Library preparation and sequencing were performed at the Technische Universität München. Briefly, volumes of 600µL DNA stabilization solution (STRATEC biomedical) and 400µL Phenol:choloform:isoamyl alcohol (25:24:1, Sigma-Aldrich) were added to the aliquots. Microbial cells were disrupted by mechanical lysis using FastPrep-24. Heat treatment and centrifugation were conducted after adding a cooling adaptor. Supernatants were treated with RNase to eliminate RNA. Total DNA was purified using gDNA columns as described in detail previously [34]. Briefly, the V3-V4 regions of 16S rRNA gene were amplified (15x15 cycles) following a previously described two-step protocol [35] using forward and reverse primers 341F-785R [36]. Purification of amplicons was performed by using the AMPure XP system (Beckmann). Next, sequencing was performed with pooled samples in paired-end modus (PE275) using an MiSeq system (Illumina, Inc.) according to the manufacturer's instructions and 25% (v/v) PhiX standard library.

Microbial profiling

Data analysis was carried out as previously described [37]. Processing of raw-reads was performed by using the IMNGS (version 1.0 Build 2007) pipeline based on the UPARSE approach [38]. Sequences were demultiplexed, trimmed to the first base with a quality score <3 and then paired. Sequences with less than 300 and more than 600 nucleotides and paired reads with an expected error >3 were excluded from the analysis. Trimming of the remaining reads was done by trimming 5 nucleotides from each end to avoid GC bias and non-random base composition. Operational taxonomic units (OTUs) were clustered at 97% sequence similarity. Taxonomy assignment was performed at 80% confidence level using the RDP classifier [39] and the SILVA ribosomal RNA gene database project [34]. Later the data was normalized using the same method as for RNA-seq described above. The microbiome was visually inspected for batch effects in PCA; none were found. The resulting OTUs table was normalized using edgeR (Version 3.28).

Datasets

[Table 1](#) shows all datasets included in the study. The glioma dataset came from diffuse intrinsic pontine glioma patients that included the host transcriptome analyzed with Agilent 44K Whole Human Genome Array G4410B and G4112F, patients copy number variation processed with the ADM-2 algorithm, and data from comparative genomic hybridization (CGH)

Table 1. Summary of samples and characteristics of the datasets used.

	Glioma	CD/UC	HSCT CD	Pouchitis
Samples (non-disease/diseased)	0/53	33/26	51/107	0/255
Sex (female/male)	28/25	42/17	22/15	101/102
Location	Cort: 20 Dipg: 22 Midl: 11	Ileum:30 Colon:29	Ileum: 48 Colon: 108 Unknown: 2	Pouch: 59 PPI: 196
SES-CD local (mean (min-max))	NA		2.15 (0–12)	NA
CDAI mean (min-max)	NA		120 (0–450)	NA
Age at diagnostic (<16/16<x<40/x>40 years)			7/11/0	
Years of disease: mean (min-max)			14 (8–28)	

PPI: pre-pouch ileum. Cort: supratentorial, midl: central nuclei, dipg: brain stem. NA not applicable; an empty cell signifies unknown. Only the HSCT CD dataset was generated by the authors, all the other datasets were previously made publicly available.

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analyzed using Mutation Surveyor software. In addition, this dataset contained information on age, localization of the tumor, sex and a numerical grading of the severity of the tumor (see Table 1) [40, 41].

An IBD-related dataset was obtained from Prof. Dr. Rosenthal and Prof. Dr. Robert Hässler. It included samples from the terminal ileum and sigma from CD, UC, infectious disease-controls and healthy controls (see Table 1) [7]. The provided data included location, gender, location, age, and the status (inflamed or non-inflamed) of the region from which the biopsy was taken. The HSCT CD cohort involved 158 samples (both host RNA and microbial DNA) from 18 CD patients undergoing HSCT in our center and 19 non-IBD controls (Table 1) [15]. In addition to the samples, clinical information such as age, sex, treatment, years since disease diagnosis, prior surgery, location of the biopsies, segmental simple endoscopic score for Crohn's disease (SES-CD), time of the HSCT and response to treatment were collected. A previously published dataset from a pouchitis study was also analyzed (Table 1) [33]. A total of 255 samples from 203 patients were used containing data for both host transcriptome and microbiome. This dataset included identifiers for the patients, whether the sample was from the pre-pouch ileum or from the pouch, the sex, the outcome of the procedure and an inflammatory severity score ISCORE. The pouch ileum might be inflamed or not.

Integration

Sparse regularized generalized canonical correlation analysis (SRGCCA), implemented in RGCCA package (version 2.12), was used for this integration analysis [42]. This variation of the RGCCA method is better suited for biological data with sparsity such as the results obtained by RNA sequencing. The scheme used to add the different canonical components was the centroid scheme, which allows one to determine the positive and negative related variables. The regularization parameters used were those suggested by the tau.estimate, which is a compromise between correlation and covariance also known as Schäfer's method [43]. When looking for the covariance from phenotypic categorical variables in order to maximize the covariance instead of the correlation 1 was used for regularization.

Numeric values from the same assay were set on the same block. Relevant clinical variables were grouped in one block unless otherwise indicated. Categorical data was encoded as binary (dummy) variables for each factor, where 0 indicates not present and 1 indicates present omitting one level. Each block was standardized to zero mean and unit variances, and then divided by the square root of the number of variables of the block with the function scale2.

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MCIA was also performed on the CD/UC, CD and pouchitis dataset using only the experimental data [28]. RGCCA was compared to MCIA by examining the area under the curve (AUC) of both methods when classifying localization on the first component of the shared latent space of MCIA and the first component of the host transcriptome on the RGCCA method.

Parameter testing

The sparse canonical correlation analysis involved three parameters besides the input data: the regularization parameter (τ) the model and the scheme. To evaluate the effect of each parameter, the one being tested was changed while keeping constant all the others. This model included weights indicating the relationship between the blocks. These parameters were tested on the glioma dataset and on the CD/UC dataset.

All models were analyzed using weights from 0 to 1 by 0.1 intervals in the relationship between blocks. These weights indicate the strength of the relationship between the variables of two blocks, the higher it is, the stronger is the relationship between the variables. To test the effect of the model, all combinations of weights were analyzed. The indicators of methods quality consist of the inner average variance explained (AVE) the outer AVE and the AVE of each block. The inner AVE is defined by how well the components of each block correlate with one other [31]. The outer AVE is defined by how well the variables of a block correlate with the component for all of the blocks. As we were interested in discovering the relationships between blocks, the inner AVE was used to select the best model, the higher the inner AVE is, the better the model.

The scheme controls how the different correlations of the canonical components are summarized. The three schemes available (horst, centroid and factorial) are compared using a simple model regarding their inner AVE and the selected genes.

τ was tested on the glioma and the CD/UC dataset between the minimum accepted value and 1 for each block.

Models were validated using 1000 bootstraps with resampling to assess the stability of the inner and outer AVE.

Models used

Different models were tested for the integration of the data from the CD or the pouchitis dataset. The first model, model 0, used only two blocks, the microbiome and the host transcriptome data with interaction between them, but with no within interactions (Model not shown).

The second family of models (models 1, 1.1 and 1.2), family 1, in addition to the microbiome and host transcriptome data, included those variables we considered clinically relevant variables including some that were related to disease activity. This model was explored because it takes into account already known information that could help reveal relevant relationships. For instance, the HSCT CD dataset included the following variables: patient ID, sex, age, age at diagnosis, previous surgery, current treatment, time after HSCT and location of the sample. Including these variables could potentially help to reveal a relationship that changes with patient's characteristics, time and location.

The last family of models (models 2, 2.1, 2.2 and 2.3), family 2, used the same information as that for family 1 models, but grouped the clinical variables into three blocks, one for demographics, one for time-related variables and one for variables related to localization of the sample. Although, this family of models is more complex than family 1 the relationships found can potentially occur independently of time, clinical variables and location, thus revealing other relationships that could not be identified using the family 1 models. All models can be found

on [S1 Data](#). Models 1 to 2.3 were modeled to utilize known, clinically relevant variables with the host transcriptome and microbiome data available.

With the glioma dataset, the microbiome block was replaced by the CGH block. In addition to the previously mentioned models, the glioma dataset was also analyzed considering all the variables from the different blocks as a single entity, which is known as a superblock [44]. A superblock is a block created with all the variables on the system usually connected with each individual block of the system being analyzed.

Only the models in which all the blocks were part of a single connected network were analyzed, thus, 31 of all possible models were filtered out. For models 1 to 2.3, all the combinations of different weights on the model matrix were analyzed. First weights 0, 0.5 and 1 were used to select the model with the highest inner AVE. To further describe the interactions of models 1.1 and 2.1, different weights from 0 to 1 by 0.1 intervals were tested; the best model of each family resulted from model 1.2 and 2.2, respectively. By taking into account a direct interaction between the microbiome and the host transcriptome we could confirm whether the results of model 2.2 had improved in model.

Results

Parameters on the glioma dataset

We first determine the best strategy to obtain the right values of the parameters on SRGCCA using the glioma dataset. This was the dataset originally used to develop and test the SRGCCA method [39]. By parameters we mean the scheme used, the regularization effect, and the models as constructed by weights, all of which can affect the final solution of the SRGCCA (See Parameters testing in Methods).

Tau controls the number of variables selected from each block, regulating the stringency of the model. Tau can be estimated using Schäfer's method [43], which tries to balance both the correlation and the covariance for selecting the variables of the block. When estimated by this method, the tau provides a good intermediate solution for numeric variables. For those blocks that encode categorical variables as numeric values, the covariance of the block with the other block is the only relevant meaning; thus, a tau value of 1 is more appropriate although several values were explored. The effect of tau on the inner AVE is shown in [Fig 1A](#), where usually an increase on tau increases the inner AVE as well, although Schäfer's method provided result is close to the optimum value.

All the weights between 0 and 1 (by 0.1 intervals) in the glioma dataset were analyzed using all three schemes: horst, centroid and factorial. The horst and the centroid scheme were similar while the factorial resulted in the most different AVE values (see [S1 Data](#)). The centroid scheme takes into account all the relationship regardless of the canonical correlation sign. This, together with its similarity to horst scheme, prompted its selection as the best scheme.

The three blocks with the best tau and the centroid scheme were analyzed by changing the weights between 0 and 1 by 0.1 intervals. According to the inner AVE, the best model was the one in which the weights (1) between the host transcriptome and location, (2) the host transcriptome and the CGH, and (3) the CGH block were linked to variables related to the location with weights of 1, 0.1 and 0.1, respectively.

When we added a superblock to the data, there was an increase of 0.01 on the inner AVE of the model (See [Methods](#) section Models used and [44]). The model with the superblock that explained most of the variance was that in which the weights of the interaction within (1) the host transcriptome, (2) between the superblock and the CGH, (3) between the host transcriptome and the localization, and (4) between CGH and the host transcriptome were 1, 1, 1 and 1/3, respectively. To see if the superblock could classify the sample by location, we plotted the

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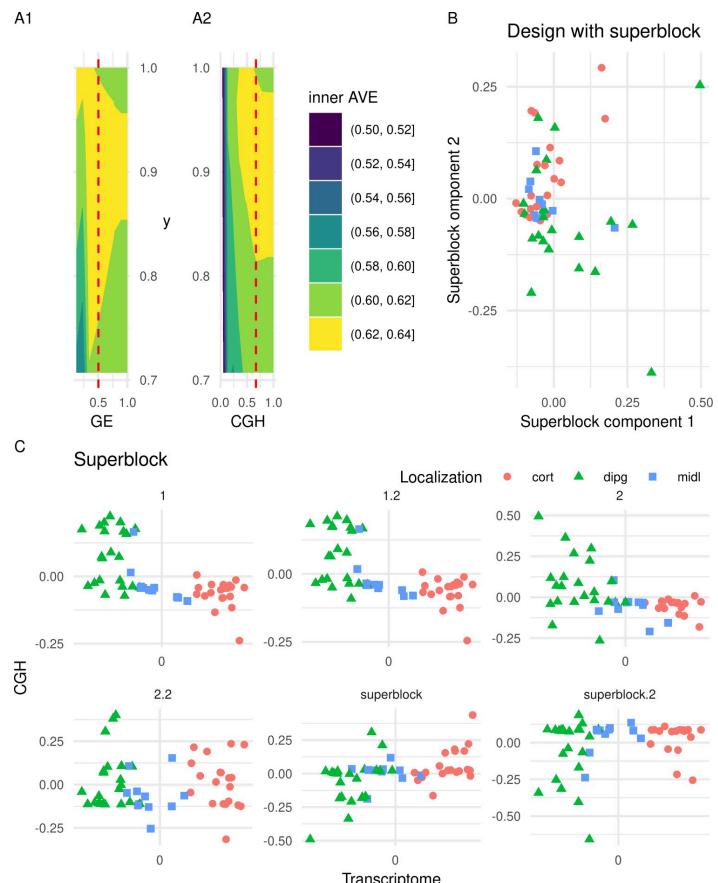


Fig 1. Analysis of the parameters on the glioma dataset. A1 and A2: A contour plot of the median of the inner AVE result of an SRGCCA with different tau values for each block (GE, gene expression of the host transcriptome, CGH (comparative genomic hybridization) for the copy number variation and y for the location). Higher tau normally increases the inner AVE, Schäfer's approximation is marked with the red vertical line. B: First two dimensions of the superblock on the glioma dataset. The first two components of the superblock within the best model, according to the inner AVE from the glioma dataset. C: First dimensions of the host transcriptome and the CGH block of models on the glioma dataset are represented. Comparison of the different models by visualizing the first components of the host transcriptome gene expression (GE) and the copy number variation (CGH) blocks from the glioma dataset. Each point represents a sample (colored by location). Cort: supratentorial, dipg: brain stem, midl: central nuclei.

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first two components of the superblock (see Fig 1B). We can clearly see that they do not classify the samples according to the location of the tumor, which is known to affect the tumor phenotype [40].

Adding one block containing the age of the patient and the severity of the tumor to the model, decreased the inner AVE. The best model with these blocks, according to the inner

AVE, was that in which the interactions (1) within the host transcriptome, (2) between the host transcriptome and the localization, (3) between the host transcriptome and (4) the CGH and between the CGH and the other variables were 1, 1, 1/3 and 1/3, respectively (see [S2 Data](#), Glioma sheet). The first components of each model can be seen in [Fig 1C](#). We can observe on the figure, the strong dependency between gene expression and location since the first model while the weaker relationship with the CGH assay [40]. On the other hand, the major difference is the dispersion on the CGH component on each model.

As the model with a superblock did not help explain the relationships between blocks, we decided not to apply it to the other datasets. The scheme selected was the centroid, which takes the absolute value of the relation between components. These parameters were used for further analysis on the CD/UC, the CD and pouchitis datasets.

Parameters on the CD/UC dataset

After an exploratory analysis of the parameters on the glioma dataset, we analyzed the CD/UC dataset, which was similar to our CD dataset and include information on both the host transcriptomics and bacterial genomics. These data were obtained using the same sequencing techniques from endoscopic biopsies.

In this dataset, the parameter tau behaved slightly differently than with the previous dataset but the value from the Schäfer's method for tau was close to the best value (see [S1 Fig](#)).

In contrast to the glioma dataset, the model with the highest inner AVE was model 1.2 ([S2 Data](#)). Model 2.2 has a relationship of 0.1 between microbiome and the host transcriptome and of 1 between the location and the host transcriptome. The microbiome block is also related by a factor of 0.1 with the demographic block and of 1 with the time block. Lastly the time and the demographic block are related by a factor of a 0.1. In either case the family 1 and family 2 models can correctly separate by sample location (colon or ileum) but not by disease type (see [Fig 2](#)) or inflammation status (data not shown).

Analyzing the models on the HSCT CD and pouchitis datasets

Having established the best parameters for analyzing a related IBD dataset, we studied our HSCT CD dataset using SRGCCA. Model 1.2 had the highest inner AVE of the family 1 model. A search for the highest inner AVE within the family 2 models resulted in model 2.2 ([S2 Data](#)). This model revealed a direct relationship between the host transcriptome and the location-related variables, while the microbiome was associated with the demographic and location-related variables (see [Fig 3](#) and [S2 Data](#)). Overall, we see that the relationships in the model affected the distribution of samples on the components of both the host transcriptome and the microbiome.

Finally, we used another related cohort to confirm the applicability of SRGCCA to an independent dataset (see [Fig 4](#)). Model 1.2 had the highest inner AVE. A search for the highest inner AVE among the family 2 models resulted in model 2.2, although it did not have a higher inner AVE than model 1.2. Moreover, no direct relationship between the host transcriptome and the clinically relevant variables was apparent ([S2 Data](#)). Family 2 models better stratified the samples by location (pouch vs pre-pouch) than did those of family 1. Nonetheless, they were separated by location-related variables in some models, albeit not as clearly as with the HSCT CD dataset. This might indicate that while sex does not affect the interaction, the location-related variables do affect the pouchitis.

Of all these models, as described above, the best according to the inner AVE on the HSCT CD dataset was model 2.2. This model explained known differences between the host

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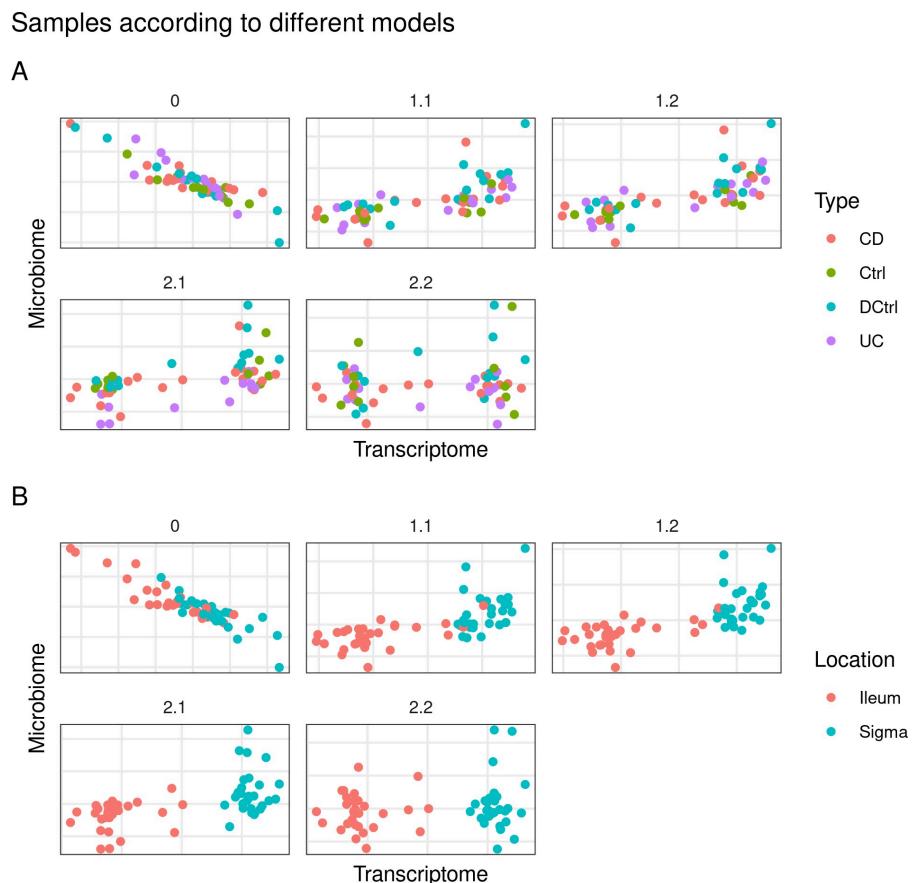


Fig 2. First dimensions of the host transcriptome and the microbiome block of models on the Crohn's disease ulcerative colitis/ dataset. Comparison of the models that better explained the interaction between the microbiome and the host transcriptome data on the CD/UC dataset. Each point represents a sample colored according to a characteristic: A) samples are colored by disease type, CD Crohn's disease, Ctrl, control; DCtrl diseased control, inflamed but not from IBD patients, UC ulcerative Colitis; and B, by location, colon or ileum, on the first components of the host transcriptome and the microbiome. Better models separate samples by tissue location using the host transcriptome component.

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transcriptome gut regions [15]. The microbiome separated the samples by disease status, indicating that it was highly relevant for the relationship with the host transcriptome.

Using the HSCT CD dataset we also looked for the best model using a single block for the clinically relevant variables, following the family model 1 structure. The model from family 1 models with the highest AVE was that in which the transcriptomics was related to the phenotype by 0.1, while the microbiome was related to the clinically relevant variables by 1. This model revealed that the relationship between the microbiome and the clinically relevant

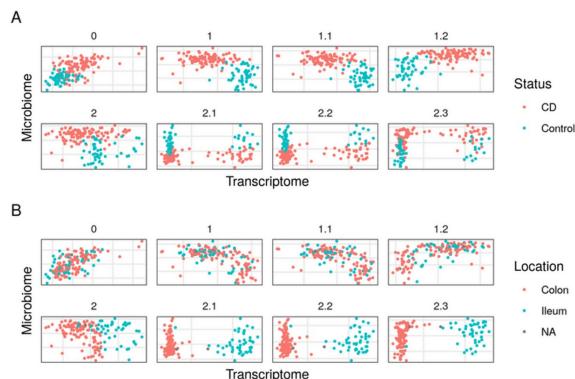


Fig 3. First dimensions of the host transcriptome and the microbiome block of models on the hematopoietic stem cell transplant Crohn's disease dataset. Comparison of the models that better explained the interaction between the microbiome and the host transcriptome data on the HSCT CD dataset. Each point represents a sample (colored by disease status): A, non-CD (Control) or CD; and B, by location, colon or ileum, on the first components of the host transcriptome and the microbiome. Better models separate samples by tissue location by the host transcriptome component and the diseased and controls samples by the microbiome component.

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variables carried more weight than that between the clinically relevant variables and the transcriptomics on the HSCT CD dataset.

In addition, the host transcriptome was related to location-dependent variables by a weight of 1, while the microbiome was related to demographic variables, and to location related variables, by a weight of 1 and 0.5, respectively. Demographic variables were also linked by 1 to the time variables block (see S2 Data, HSCT_CD sheet).

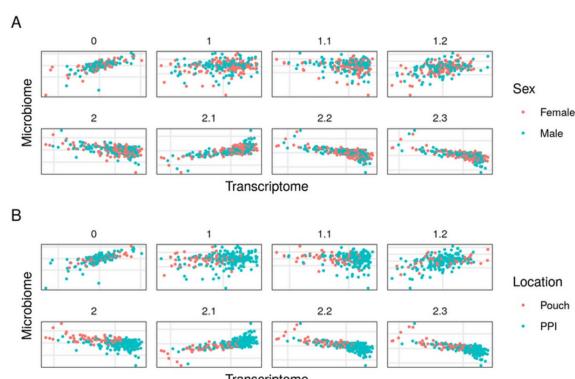


Fig 4. First dimensions of the host transcriptome and the microbiome block of models on the pouchitis dataset. Comparison of the models vis-à-vis on the pouchitis dataset by the first component of the host transcriptome and the microbiome from the HSCT CD dataset. Each point represents a sample colored by sex (A), where females are in red and males in blue, and by location (B), where the pouch is the red, and PPI is the pre-pouch ileum. The samples do not show a sex-specific pattern but on the best models the host transcriptome partially separates pouch and pre-pouch ileum samples.

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The interaction of genes within the host transcriptome was also analyzed on the HSCT CD dataset. Adding this interaction increased the inner AVE score between 0.10 and 0.03 depending on the model. However, it was not deemed important to find the relationships between the host transcriptome and the microbiome and thus was not compared between datasets.

Genes selected by SRGCCA as related to the microbiome in our HSCT CD dataset were different between the family 1 and 2 models (see Fig 5A), suggesting that the relationship between microorganisms and genes is independently influenced by location, time and demographic-related variables. The influence of the microbiome remained constant as indicated by the high number of OTUs shared between family 1 and 2 models suggesting that previously observed differences might have been due to covariates since the microorganisms identified by multiple models remained unchanged (Fig 5B).

Comparison of models

As expected, when analyzing the same dataset with different models the output results in different relevant variables. In order to analyze the accuracy of the models, one thousand bootstraps were used to integrate the data from the HSCT CD dataset (Fig 4 and Table 2). Each model had its own dispersion on the same bootstrapped samples (Fig 6). The lower the dispersion, the more robust the model was to different conditions than in the initial testing.

Model 2.2 had both higher inner and outer AVE mean values and less standard deviation (Fig 4 and Table 2). This indicates that it was more robust than the other models, regardless of the input data.

The bootstrap analysis of the one thousand bootstraps on the pouchitis dataset showed that model 1.2 had the highest mean inner AVE, while model 0 had the highest mean outer AVE (Table 3). Overall, model 1.2 was considered the most robust.

The models with the highest inner AVE were more robust to different data, which indicates that they can be applied more generally and not solely to these samples.

Comparison of methods

We have seen that this method provides robust models of the interactions on the datasets. However, given the many methods available for integration multiple omics, we sought to determine how these methods would perform compared to other existing approaches. In particular, we ran a comparison with MCIA, which is a newer method that requires less parameters while still being conceptually similar to SRGCCA.

Applying MCIA to the CD/UC, HSCT CD and pouchitis datasets produced similar distribution on the synthetic space compared to our method (Fig 7). This method was able to classify the samples by their location on the first component in a manner similar to our own method with the first transcriptomic component. On the pouchitis dataset neither method could separate the samples by location while MCIA did worse than our best model according to the AUC. In all three datasets the best model outperformed MCIA when classifying the samples according to their location (Fig 7), with the greater difference involving the pouchitis dataset (data not shown).

Discussion

This study provides a framework for identifying interactions between blocks of data, a step towards understanding biological relationships between datasets or between datasets and other particularly relevant variables. First, we studied the parameters' influence on a glioma and CD/UC dataset, adjusting their values and testing how generalizable they are. Then, we

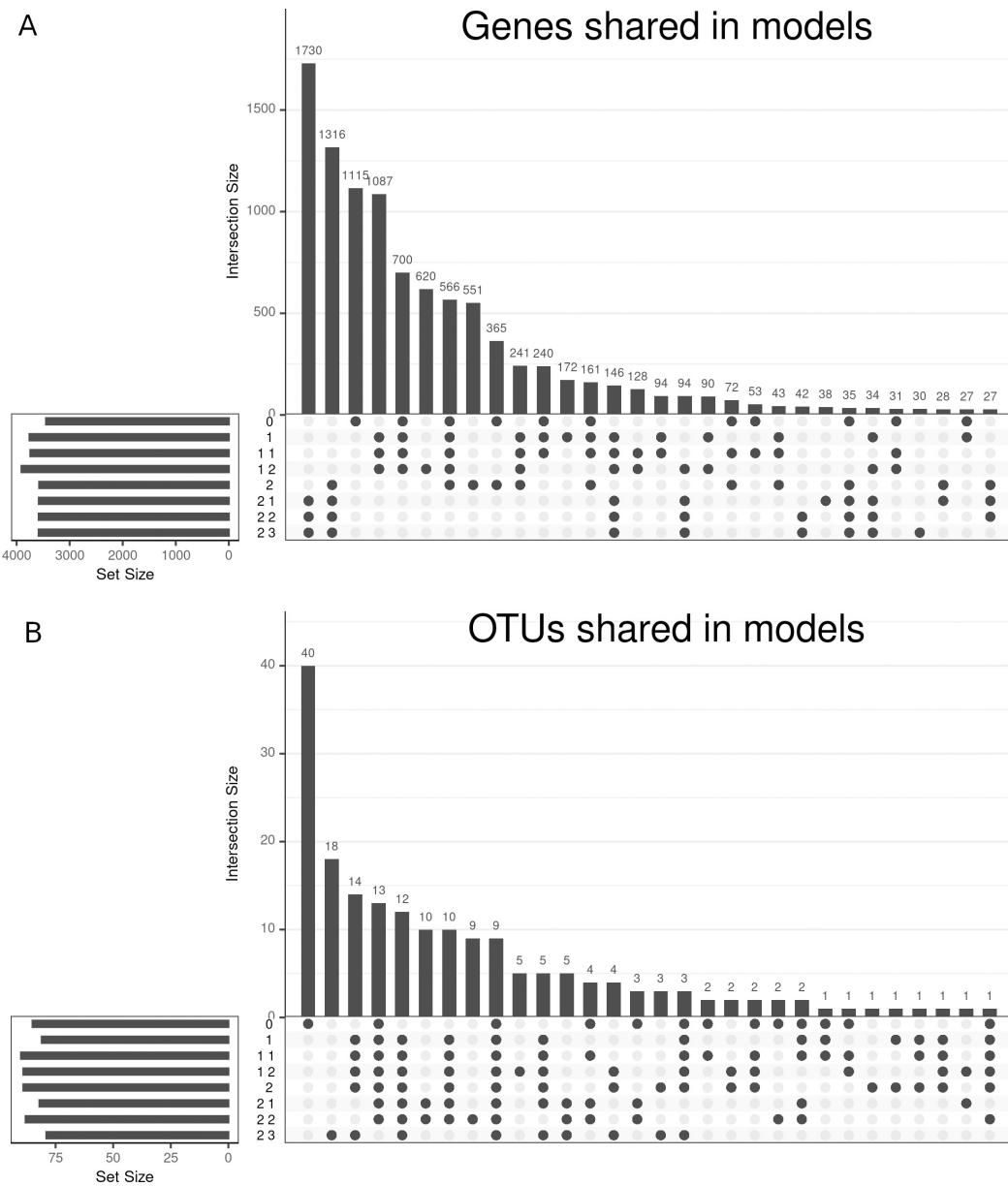


Fig 5. UpSet plot of the of the models on the hematopoietic stem cell transplant Crohn's disease dataset. The heights of the bars represent the genes (A) or OTUs (B) shared between the models selected by the points; 30 intersections are shown.

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Table 2. Bootstrapped mean and standard deviation of inner and outer AVE values on the HSCT CD dataset.

Model	AVE	Mean	Sd
0	inner	0,550	0,0469
1.2	inner	0,768	0,0223
2.2	inner	0,785	0,0163
0	outer	0,104	0,0132
1.2	outer	0,088	0,0106
2.2	outer	0,105	0,0069

The best models according to the mean are shown in bold.

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developed a method to find the best model for the relationships between blocks. Lastly, we validated the method in two independent datasets.

We explored the regularization of the blocks on two previously published datasets from glioma and IBD patients. The regularization of a block modulates how many variables are selected and whether correlation or covariance have to be used when looking for the canonical correlation with other blocks [28, 30]. A tau value of 1 allowed us to select all variables, which maximized their covariance. On blocks that included only clinically relevant categorical variables, regularization must be equal to 1, since correlations with categorical variables have a different meaning. As the host transcriptome and microbiome blocks contain many variables, a shrinkage parameter closer to 0 was expected, as observed with the glioma and the CD/UC datasets. In addition, estimating tau for the quantitative blocks resulted in higher inner AVE scores since the quantitative variables that contributed most to the data variation were selected.

Based on the regularization obtained, we explored different schemes of integration on the glioma dataset. The resulting canonical components of the centroid and horst schemes did differ in some models. In fact, the canonical correlations between blocks were likely positive, making the differences between these two schemes unobservable. The centroid scheme was selected to analyze the CD and the pouchitis datasets, since canonical correlations are not always positive.

Independently of the scheme involved, a superblock not only aids in interpretation, but also helps account for the possibility of interactions between variables of the same block. The increase observed in the inner AVE may have stemmed from the interaction between variables of the same block. However, such an interpretation is not as clear as with blocks generated by a single assay or from closely related variables [30]. The superblock, which is used for redundancy analysis, did not help in terms of grouping different samples [44]. Moreover, if the goal of the model is to accurately represent the system under study, the superblock is not necessary, regardless of the assistance it provides in improving the inner AVE.

The superblock is usually related to all the other blocks. Typically, a weight of 1 is used to indicate a direct relationship between two blocks. Modifying the weights of the model influenced the result by changing AVE scores and the variables selected from each block. The highest inner AVE score was not defined by the highest weights on all the relationships.

The weights of the models represent how much one block interacts with another if the interactions are linear, an assumption of any canonical correlation [31]. In such cases, the weights are representative of the interactions between blocks.

The weights define the relationships between blocks in SRGCCA, which together determine the model of the components. Other methods like MCIA and joint and individual variation-explained (JIVE) assume a common relationship between all components, which results in a

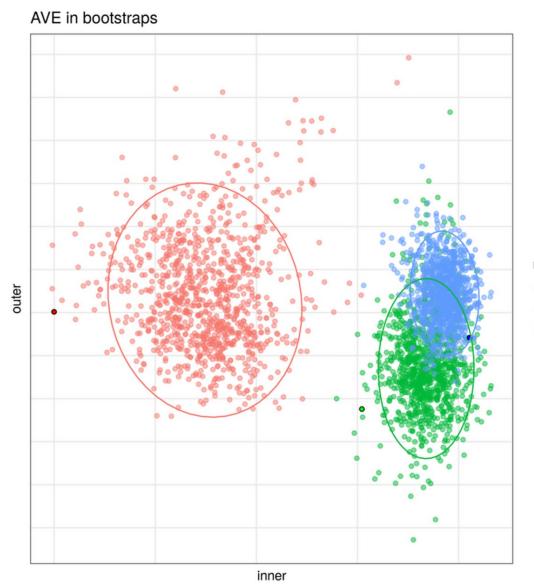


Fig 6. Bootstrap results of three models on the hematopoietic stem cell transplant Crohn's disease dataset.
Variance of AVE using the same samples on three models with the HSCT CD dataset. Each point shows the AVE for each analysis performed. The brighter colors reflect the result of this model on the original data (including all samples). Dispersion on the bootstrapped samples is reduced as a model more accurately represents the relationships present on the dataset.

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common space for the samples [27, 28]. This difference is crucial for exploring the role of the components; for example, in our manuscript each model represents the same system with different interactions and assumptions. Comparing different models after the SRGCCA led to explanations for different aspects of the same system. Here, we also show that compared to our method, MCIA can result in similar samples' classification on a latent space. However, it was not always as good as was evident by the AUC when classifying the samples by location. In addition, the interpretation of the MCIA was not as straight forward as with SRGCCA. Furthermore, with our method the observed classification of the samples according to their

Table 3. Bootstrapped mean and standard deviation of inner and outer AVE values on the pouchitis dataset.

Model	AVE	Mean	Sd
0	inner	0,448	0,0811
1.2	inner	0,820	0,0457
2.2	inner	0,767	0,0332
0	outer	0,140	0,0087
1.2	outer	0,120	0,0227
2.2	outer	0,134	0,0085

The models with the higher mean AVE values are shown in bold.

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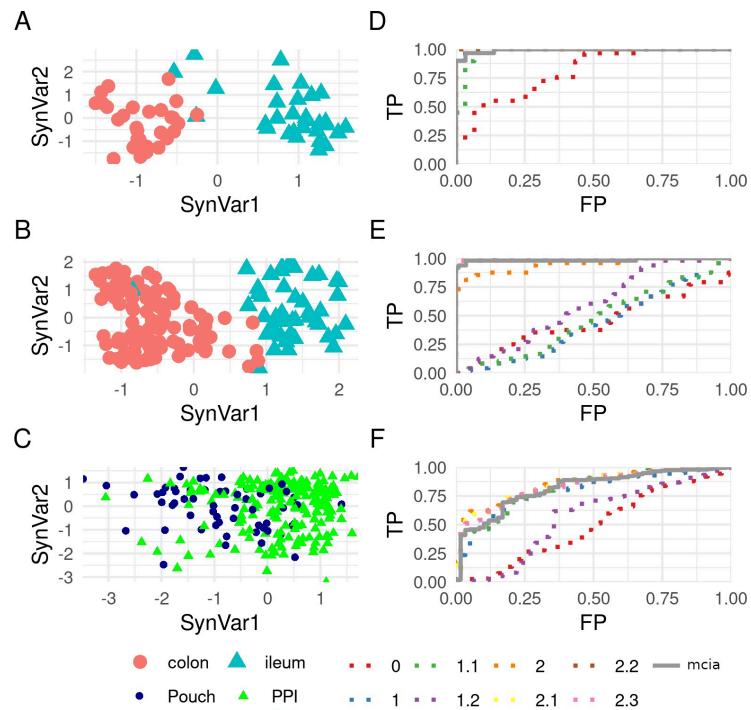


Fig 7. Multiple co-inertia analysis and area under the curve for the location of the Crohn's disease/ulcerative colitis, the hematopoietic stem cell transplant Crohn's disease and pouchitis dataset. A, B, C plots are the results of applying multiple co-inertia analysis (MCIA) where the horizontal and vertical axis represent the synthetic variable 1 and 2 respectively. D, E, F plots are the area under the curve (AUC) for all the methods applied on this dataset. The first row (A, D) is the analysis of CD/UC dataset, the second one (B, E) the HSCT CD dataset, and the third one (C, F) the pouchitis dataset.

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location can be directly attributed to the host transcriptome while with MCIA that effect could result from either the host transcriptome or the microbiome.

Looking at the glioma data, the best model according to the inner AVE was that with the superblock. As previously explained, this model might represent the hierarchical relationships present in the data. However, the superblock did not provide more interpretable results in the glioma dataset.

In the glioma dataset, the model lacking the superblock but with the highest inner AVE indicated that the localization of a tumor influences the host transcriptome to a greater degree than the copy number variations, if the relationships are linear. Adding supplementary information on the samples' localization did not increase the inner AVE, suggesting that there was a high dependence between localization and the tumor host transcriptome.

Interactions within the host transcriptome usually increase the inner AVE of the models. With the CD and the pouchitis datasets, self-interaction increased the inner AVE, as well as the selected features, except in models 0 to 1.2 in the CD data set. This suggests that the interactions within the same omic block become relevant if the model does not take into account

the interaction between other clinically relevant variables. If other relevant variables are included, then the effect of this interaction is significantly less.

Model 0 looked for direct relationships between the microbiome and the host transcriptome. Confounders that influence both host transcriptome and microbiome, such as age or the localization and inflammation status, were not taken into account in this model. This is due to the fact that they can bias the relations found with this model [45]. Nonetheless, this model was capable of grouping the samples of the CD dataset according to their disease status, though this was not true of the pouchitis dataset.

Family 1 models use three blocks, including one for clinically important information about the samples. This new block was added to avoid biasing the integration by known factors of the samples such as sex, or location. In the best model of this family, the microbiome block had a weak relationship with the host transcriptome. This weak relationship was possibly an indicative of not lineal relations. If the relationships were not lineal, then they could not be fully identified by RGCCA [31]. Another possibility is that the microbiome was related to other variables not included on the dataset.

Finally, family 2 models, compared to those of family 1, were designed to explain the relationship between the microbiome and host transcriptome, allowing for the presence of independent interactions with location, age and other demographic-related variables. In family 1 models all the relevant variables were mixed together. In order to allow for such interactions, unrelated variables were separated in different blocks.

In the HSCT CD dataset, a cursory analysis confirmed that the genes selected by SRGCCA with model 2.2 were related to the sample location [15]. The selected microorganisms previously linked to CD dysbiosis were *Faecalibacterium* sp. and *Bacteroides* sp. (see S3 Data) [46]. This suggests that the variables selected were relevant for their role in both the tissue and the disease. Thus, the genes and microorganisms that have significant relationships were likely to be present in this context.

There are several previously known interactions between the variables collected on the multiple datasets. For instance the butyrate produced by the microbiome affects the state of the epithelial cells, implying a relationship between the microbiome and the host transcriptome [47]. It is also known that the microbiome changes along the gastrointestinal tract; thus, the microbiome and host transcriptome blocks must be connected [48]. Moreover, the microbiome is influenced by diet, which would imply a relationship between demographics and the microbiome [49]. In addition, there are some studies that observe changes over time, with perhaps additional links to changes in diet. With our method we could a connection between all of these blocks.

In the pouchitis dataset, model 1.2 captured a greater degree of variance than model 2.2, contrary to the results obtained with the HSCT CD dataset. This might be because potentially important variables, such as age, were lacking and possibly because the model was confounded. In addition, we could not make direct comparisons with the HSCT CD dataset as it did not include non-diseased samples although it did include non-inflamed samples. This is due to the fact that the model differentiates by subgroups of patients instead of by a distinct relationship between healthy and diseased samples.

The findings of this study have to be assessed in light of certain limitations. RGCCA cannot describe a causal relationship or the mechanisms underlying the relationships between RNA transcriptomics and the microbiome. However, models for RGCCA can be used to select variables for further studies and experiments in order to validate these relationships. This method has been implemented in an R package, called inteRmodel, which can be found at <https://github.com/lhrs/inteRmodel/>. This package implements the methodology described in this manuscript and also incorporate some help functions for the analysis.

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When examining an interaction within a block, we only assumed the existence of an interaction within the host transcriptome. However, it must be noted that microorganisms create communities for which the interactions of several microorganisms is essential and we did not consider interaction within the microbiome in the present study [50]. Knowing how microbial communities rise and interact remains an open question that could affect any interpretation of the results [50, 51]. In addition, the taxonomy imputation can be biased by the copy number variation of the 16S rRNA present on the microbiome. This problem has not yet been solved, and the workflow used could over-estimate the abundance of some taxonomies [52].

In the present study, as we did not use a simulated data set with known relationships between blocks, we could not assess the specificity or sensitivity of our approach. In addition, we could not confirm by further analysis and experiments whether the selected variables were necessary to start or maintain CD or pouchitis.

Conclusions

RGCCA is a powerful integration tool. We have shown that the model is the most important parameter when selecting variables. The weights of the model represent the strengths of the relationships between blocks. Here we propose a robust methodology implemented with inteRmodel, to identify the best models guided by the inner AVE when there is no prior knowledge of the existing relationship.

This method can identify relationships in complex systems such as Crohn's disease by taking into account the interactions between the microbiome, host transcriptome and the relevant clinical variables. The resulting analysis can improve our understanding of the biological relationships between different omics datasets and other relevant (clinical) variables.

Supporting information

S1 Data. Schemes types and AVE on the glioma dataset.
(XLSX)

S2 Data. Models design representations.
(XLSX)

S3 Data. Variables selected by the model 2.2 on the HSCT CD dataset.
(XLSX)

S1 Fig. Tau effect on the CD/UC dataset.
(TIF)

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References

1. Tomczak K, Czerwińska P, Wiznerowicz M. The Cancer Genome Atlas (TCGA): an immeasurable source of knowledge. *Contemp Oncol Poznań Pol.* 2015; 19: A68–77. <https://doi.org/10.5114/wo.2014.47136> PMID: 25691825
2. Human Microbiome Project Consortium BA, Nelson KE, Pop M, Creasy HH, Giglio MG, Huttenhower C, et al. A framework for human microbiome research. *Nature.* 2012; 486: 215–21. <https://doi.org/10.1038/nature11209> PMID: 22699610
3. Beale DJ, Karpe AV, Ahmed W. Beyond Metabolomics: A Review of Multi-Omics-Based Approaches. In: Beale DJ, Kouremenos KA, Palombo EA, editors. *Microbial Metabolomics: Applications in Clinical, Environmental, and Industrial Microbiology.* Cham: Springer International Publishing; 2016. pp. 289–312. https://doi.org/10.1007/978-3-319-46326-1_10
4. Holmberg FE, Seidelin JB, Yin X, Mead BE, Tong Z, Li Y, et al. Culturing human intestinal stem cells for regenerative applications in the treatment of inflammatory bowel disease. *EMBO Mol Med.* 2017; 9: 558–570. <https://doi.org/10.15252/emmm.201607260> PMID: 28283650
5. McIlroy J, Ianiro G, Mukhopadhyay I, Hansen R, Hold GL. Review article: the gut microbiome in inflammatory bowel disease—avenues for microbial management. *Aliment Pharmacol Ther.* 2018; 47: 26–42. <https://doi.org/10.1111/apt.14384> PMID: 29034981
6. Øyri SF, Múzes G, Sipos F. Dysbiotic gut microbiome: A key element of Crohn's disease. *Comp Immunol Microbiol Infect Dis.* 2015; 43: 36–49. <https://doi.org/10.1016/j.cimid.2015.10.005> PMID: 26616659
7. Häslar R, Sheibani-Tezerji R, Sinha A, Barann M, Rehman A, Esser D, et al. Uncoupling of mucosal gene regulation, mRNA splicing and adherent microbiota signatures in inflammatory bowel disease. *Gut.* 2016; gutjnl–2016–311651. <https://doi.org/10.1136/gutjnl-2016-311651> PMID: 27694142
8. Haberman Y, Tickle TL, Dexheimer PJ, Kim M-O, Tang D, Karns R, et al. Pediatric Crohn disease patients exhibit specific ileal transcriptome and microbiome signature. *J Clin Invest.* 2014; 124: 3617–3633. <https://doi.org/10.1172/JCI75436> PMID: 25003194
9. Loganathan P, Catinella AP, Hashash JG, Gajendran M, Loganathan P, Catinella AP, et al. A comprehensive review and update on Crohn's disease. *Dis Mon.* 2018; 64: 20–57. Available: <http://www.ncbi.nlm.nih.gov/pubmed/28826742> <http://linkinghub.elsevier.com/retrieve/pii/S0011502917301530> <https://www.sciencedirect.com.sire.ub.edu/science/article/pii/S0011502917301530?via%3Dihub> <https://doi.org/10.1016/j.dismonth.2017.07.001> PMID: 28826742
10. Azimi T, Nasiri MJ, Chirani AS, Pouriran R, Dabiri H. The role of bacteria in the inflammatory bowel disease development: a narrative review. *APMIS.* 2018; 126: 275–283. <https://doi.org/10.1111/apm.12814> PMID: 29508438
11. Hata K, Ishihara S, Nozawa H, Kawai K, Kiyomatsu T, Tanaka T, et al. Pouchitis after ileal pouch-anal anastomosis in ulcerative colitis: Diagnosis, management, risk factors, and incidence. *Dig Endosc Off J Jpn Gastroenterol Endosc Soc.* 2017; 29: 26–34. <https://doi.org/10.1111/den.12744> PMID: 27681447

C.1. INTERMODEL: PAPER

12. De Souza HSP, Fiocchi C, Iliopoulos D. The IBD interactome: An integrated view of aetiology, pathogenesis and therapy. 2017; 14: <https://doi.org/10.1038/nrgastro.2017.110> PMID: 28831186
13. Gaujoux R, Starosvetsky E, Maimon N, Vallania F, Bar-Yoseph H, Pressman S, et al. Inflammatory bowel disease Cell-centred meta-analysis reveals baseline predictors of anti-TNF α non-response in biopsy and blood of patients with IBD. Gut. 2018; 0: 1–11. <https://doi.org/10.1136/gutnl-2017-315494> PMID: 29618496
14. Huang H, Vangay P, McKinlay CE, Knights D. Multi-omics analysis of inflammatory bowel disease. Immunol Lett. 2014; 162: 62–68. <https://doi.org/10.1016/j.imlet.2014.07.014> PMID: 25131220
15. Corraliza AM, Ricart E, López-García A, Carme Masamunt M, Very M, Esteller M, et al. Differences in Peripheral and Tissue Immune Cell Populations Following Haematopoietic Stem Cell Transplantation in Crohn's Disease Patients. J Crohns Colitis. [cited 25 Jan 2019]. <https://doi.org/10.1093/ecco-jcc/jyy203> PMID: 30521002
16. Tang MS, Bowcutt R, Leung JM, Wolff MJ, Gundra UM, Hudesman D, et al. Integrated Analysis of Biopsies from Inflammatory Bowel Disease Patients Identifies SAA1 as a Link Between Mucosal Microbes with TH17 and TH22 Cells. Inflamm Bowel Dis. 2017; 23: 1544–1554. <https://doi.org/10.1097/MIB.0000000000001208> PMID: 28806280
17. Gevers D, Kugathasan S, Denson LA, Vázquez-Baeza Y, Van Treuren W, Ren B, et al. The Treatment-Naïve Microbiome in New-Onset Crohn's Disease. Cell Host Microbe. 2014; 15: 382–392. <https://doi.org/10.1016/j.chom.2014.02.005> PMID: 24629344
18. Presley LL, Ye J, Li X, LeBlanc J, Zhang Z, Ruegger PM, et al. Host-Microbe Relationships in Inflammatory Bowel Disease Detected by Bacterial and Metaproteomic Analysis of the Mucosal-Luminal Interface. Inflamm Bowel Dis. 2012; 18: 409–417. <https://doi.org/10.1002/ibd.21793> PMID: 21698720
19. Lopez-Siles M, Enrich-Capó N, Aldeguer X, Sabat-Mir M, Duncan SH, Garcia-Gil LJ, et al. Alterations in the Abundance and Co-occurrence of Akkermansia muciniphila and Faecalibacterium prausnitzii in the Colonic Mucosa of Inflammatory Bowel Disease Subjects. Front Cell Infect Microbiol. 2018; 8. <https://doi.org/10.3389/fcimb.2018.00281> PMID: 30245977
20. Saccani E, Hoefsloot HCJ, Smilde AK, Westerhuis JA, Hendriks MMWB. Reflections on univariate and multivariate analysis of metabolomics data. Metabolomics. 2014; 10: 361–374. <https://doi.org/10.1007/s11306-013-0598-6>
21. Lovell D, Pawlowsky-Glahn V, Egozcue JJ, Marguerat S, Bähler J. Proportionality: A Valid Alternative to Correlation for Relative Data. PLOS Comput Biol. 2015; 11: e1004075. <https://doi.org/10.1371/journal.pcbi.1004075> PMID: 25775355
22. Cavill R, Jennen D, Kleinjans J, Briedé JJ. Transcriptomic and metabolomic data integration. Brief Bioinform. 2016; 17: 891–901. <https://doi.org/10.1093/bib/bbv090> PMID: 26467821
23. Chong J, Xia J. Computational Approaches for Integrative Analysis of the Metabolome and Microbiome. Metabolites. 2017; 7: 62. <https://doi.org/10.3390/metabol07040062> PMID: 29156542
24. Segata N, Izard J, Waldron L, Gevers D, Miropolsky L, Garrett WS, et al. Metagenomic biomarker discovery and explanation. Genome Biol. 2011; 12: R60. <https://doi.org/10.1186/gb-2011-12-6-r60> PMID: 21702898
25. Rohart F, Gautier B, Singh A, Cao K-AL. mixOmics: An R package for 'omics' feature selection and multiple data integration. PLOS Comput Biol. 2017; 13: e1005752. <https://doi.org/10.1371/journal.pcbi.1005752> PMID: 29099853
26. Deun KV, Mechelen IV, Thorrez L, Schouteden M, Moor BD, Werf MJ van der, et al. DISCO-SCA and Properly Applied GSVD as Swinging Methods to Find Common and Distinctive Processes. PLOS ONE. 2012; 7: e37840. <https://doi.org/10.1371/journal.pone.0037840> PMID: 22693578
27. Lock EF, Hoadley KA, Marron JS, Nobel AB. Joint and individual variation explained (JIVE) for integrated analysis of multiple data types. Ann Appl Stat. 2013; 7: 523–542. <https://doi.org/10.1214/12-AOAS597> PMID: 23745156
28. Meng C, Kuster B, Culhane AC, Gholami AM. A multivariate approach to the integration of multi-omics datasets. BMC Bioinformatics. 2014; 15: 162. <https://doi.org/10.1186/1471-2105-15-162> PMID: 24884486
29. Witten DM, Tibshirani R, Hastie T. A penalized matrix decomposition, with applications to sparse principal components and canonical correlation analysis. Biostatistics. 2009; 10: 515–534. <https://doi.org/10.1093/biostatistics/kxp008> PMID: 19377034
30. Tenenhaus A, Tenenhaus M. Regularized generalized canonical correlation analysis for multiblock or multigroup data analysis. Eur J Oper Res. 2014; 238: 391–403. <https://doi.org/10.1093/biostatistics/kxu001> PMID: 24550197
31. Tenenhaus A, Tenenhaus M. Regularized Generalized Canonical Correlation Analysis. Psychometrika. 2011; 76: 257–284. <https://doi.org/10.1007/s11336-011-9206-8>

32. Löfstedt T, Hadj-Salem F, Guillermot V, Philippe C, Raymond N, Duchesney E, et al. A general multi-block method for structured variable selection. ArXiv161009490 Stat. 2016 [cited 29 Jun 2018]. Available: <http://arxiv.org/abs/1610.09490>
33. Lagkouvardos I, Kläring K, Heinemann SS, Platz S, Scholz B, Engel K-H, et al. Gut metabolites and bacterial community networks during a pilot intervention study with flaxseeds in healthy adult men. Mol Nutr Food Res. 2015; 59: 1614–1628. <https://doi.org/10.1002/mnfr.201500125> PMID: 25988339
34. Berry D, Ben Mahfoudh K, Wagner M, Loy A. Barcoded primers used in multiplex amplicon pyrosequencing bias amplification. Appl Environ Microbiol. 2011; 77: 7846–7849. <https://doi.org/10.1128/AEM.05220-11> PMID: 21890669
35. Klindworth A, Pruesse E, Schweer T, Peplies J, Quast C, Horn M, et al. Evaluation of general 16S ribosomal RNA gene PCR primers for classical and next-generation sequencing-based diversity studies. Nucleic Acids Res. 2013; 41: e1–e1. <https://doi.org/10.1093/nar/gks808> PMID: 22933715
36. Lagkouvardos I, Joseph D, Kapfhammer M, Giritli S, Horn M, Haller D, et al. IMNGS: A comprehensive open resource of processed 16S rRNA microbial profiles for ecology and diversity studies. Sci Rep. 2016; 6. <https://doi.org/10.1038/s41598-016-0015-2> PMID: 28442741
37. Edgar RC. UPARSE: highly accurate OTU sequences from microbial amplicon reads. Nat Methods. 2013; 10: 996–998. <https://doi.org/10.1038/nmeth.2604> PMID: 23955772
38. Wang Q, Garrity GM, Tiedje JM, Cole JR. Naïve Bayesian Classifier for Rapid Assignment of rRNA Sequences into the New Bacterial Taxonomy. Appl Environ Microbiol. 2007; 73: 5261–5267. <https://doi.org/10.1128/AEM.00062-07> PMID: 17586664
39. Puget S, Philippe C, Bax DA, Job B, Varlet P, Junier M-P, et al. Mesenchymal Transition and PDGFRA Amplification/Mutation Are Key Distinct Oncogenic Events in Pediatric Diffuse Intrinsic Pontine Gliomas. PLOS ONE. 2012; 7: e30313. <https://doi.org/10.1371/journal.pone.0030313> PMID: 22389665
40. Morgan XC, Kabakchiev B, Waldron L, Tyler AD, Tickle TL, Milgrom R, et al. Associations between host gene expression, the mucosal microbiome, and clinical outcome in the pelvic pouch of patients with inflammatory bowel disease. Genome Biol. 2015; 16: 67. <https://doi.org/10.1186/s13059-015-0637-x> PMID: 25887922
41. Sparse Generalized Canonical Correlation Analysis. [cited 26 Sep 2018]. Available: <http://biodev.cea.fr/sgcca/>
42. Tenenhaus A, Philippe C, Guillermot V, Le Cao K-A, Grill J, Frouin V. Variable selection for generalized canonical correlation analysis. Biostatistics. 2014; 15: 569–583. <https://doi.org/10.1093/biostatistics/kxu001> PMID: 24550197
43. Schäfer J, Strimmer K. A Shrinkage Approach to Large-Scale Covariance Matrix Estimation and Implications for Functional Genomics. Stat Appl Genet Mol Biol. 2005; 4. <https://doi.org/10.2202/1544-6115.1175> PMID: 16646851
44. Tenenhaus M, Tenenhaus A, Groenen PJF. Regularized Generalized Canonical Correlation Analysis: A Framework for Sequential Multiblock Component Methods. Psychometrika. 2017; 82: 737–777. <https://doi.org/10.1007/s11336-017-9573-x> PMID: 28536930
45. Aleman FDD, Valenzano DR. Microbiome evolution during host aging. PLOS Pathog. 2019; 15: e1007727. <https://doi.org/10.1371/journal.ppat.1007727> PMID: 31344129
46. Wen L, Duffy A. Factors Influencing the Gut Microbiota, Inflammation, and Type 2 Diabetes. J Nutr. 2017; 147: 1468S–1475S. <https://doi.org/10.3945/jn.116.240754> PMID: 28615382
47. Schirmer M, Franzosa EA, Lloyd-Price J, McVer LJ, Schwager R, Poon TW, et al. Dynamics of meta-transcription in the inflammatory bowel disease gut microbiome. Nat Microbiol. 2018; 3: 337–346. <https://doi.org/10.1038/s41564-017-0089-z> PMID: 29311644
48. Ferrer-Picón E, Dotti I, Corraliza AM, Mayorgas A, Esteller M, Perales JC, et al. Intestinal Inflammation Modulates the Epithelial Response to Butyrate in Patients With Inflammatory Bowel Disease. Inflamm Bowel Dis. 2020; 26: 43–55. <https://doi.org/10.1093/ibd/izz119> PMID: 31211831
49. Hillman ET, Lu H, Yao T, Nakatsu CH. Microbial Ecology along the Gastrointestinal Tract. Microbes Environ. 2017;advpub. <https://doi.org/10.1264/jsme2.ME17017> PMID: 29129876
50. Stubbendieck RM, Vargas-Bautista C, Straight PD. Bacterial Communities: Interactions to Scale. Front Microbiol. 2016; 7. <https://doi.org/10.3389/fmicb.2016.01234> PMID: 27551280
51. Koren O, Knights D, Gonzalez A, Waldron L, Segata N, Knight R, et al. A Guide to Enterotypes across the Human Body: Meta-Analysis of Microbial Community Structures in Human Microbiome Datasets. PLOS Comput Biol. 2013; 9: e1002863. <https://doi.org/10.1371/journal.pcbi.1002863> PMID: 23326225
52. Louca S, Doebeli M, Parfrey LW. Correcting for 16S rRNA gene copy numbers in microbiome surveys remains an unsolved problem. Microbiome. 2018; 6: 41. <https://doi.org/10.1186/s40168-018-0420-9> PMID: 29482646

C.2. EXPERDESIGN: STRATIFYING SAMPLES INTO BATCHES WITH MINIMAL BIAS

C.2 experDesign: stratifying samples into batches with minimal bias

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experDesign: stratifying samples into batches with minimal bias

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Summary

The design of an experiment is critical to its success. Nonetheless, even when correctly designed, the process leading up to the moment of measuring a given variable is critical. At any one of the several steps, from sample collection to measurement of a variable, various errors and problems can affect the experimental results. Failure to take such variability into account can render an experiment inconclusive. *experDesign* provides tools to minimize the risk of inconclusive results by assigning samples to batches to reduce potential batch effects.

Introduction

To design an experiment that can support conclusive results upon analysis, the source of the variation between samples must be identified. Typically, one can control the environment in which the study or experiment is being conducted. Sometimes, however, this is not possible. In such cases, techniques to control variations must be applied. There are three methods used to decrease the uncertainty of the unwanted variation: blocking, randomization and replication (Klaus 2015).

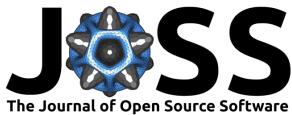
Blocking is a method that groups samples that are equal according to one or more variables, allowing the estimation of the differences between each batch by comparing measurements within the blocks. **Randomization** minimizes the variation in the measurements by randomly mixing the potential confounding variables. **Replication** increases the number of samples used in an experiment to better estimate the variation of the experiment. In some settings these techniques can be applied together to enhance the robustness of the study.

Between the designing of an experiment and the measurement of the samples, some samples might be lost, contaminated, or degraded below the quality threshold. In addition, experiments will occasionally need to be carried out in batches. The later might be needed for technical reasons; for example, the device cannot measure more than a given number of samples at the same time. Practical reasons can also be a factor; for instance, it may not be possible to obtain additional measurements in the field during the allotted time.

This divergence from the original design might cause batch effects, thereby perturbing the analysis. There are several techniques to identify and assess batch effects when analyzing an already measured experiment (Leek et al. 2010). It would be better to avoid such batch effects before executing an experiment. By taking into account the differences between the original design and the state before the measurement is conducted, confounding effects can be minimized.

To prevent the batch effect from confounding the analysis after the initial design of the experiment, there are two options: randomization and replication. Randomization, consists of

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shuffling the samples in order to mix different attributes, which can help reduce variations across groups. In contrast, replication helps estimate the variation of the measurements or samples, thus increasing the precision of the estimates of the true value obtained by the analysis. Replications consist of increasing the number of measurements with similar attributes. When a sample is measured multiple times, this is referred to as a technical replicate. Technical replicates help estimate the variation of the measurement method, and thus the possible batch effect (Blainey, Krzywinski, and Altman 2014).

Randomization and replication can be used to prevent batch effects that might confound the analysis. By examining how the variables are distributed across each batch, proper randomization can be ensured, thus minimizing batch effects. This is known as randomized block experimental design or stratified random sampling experimental design.

State of the art

There are certain tools that can minimize batch effects on the R language in multiple fields, particularly for biological research (R Core Team 2014). Here we briefly describe the currently available packages:

- **OSAT**, at Bioconductor, first allocates the samples from each batch according to a variable; it then shuffles the samples from each batch in order to randomize the other variables (Yan et al. 2012). This algorithm relies on categorical variables and cannot use numerical variables (e.g., those that are age- or time-related) unless they are treated as categorical variables.
OSAT provides templates for plates that hold 2, 4, 8 Illumina BeadChip chips, having 24, 48 or 96 wells. Moreover, it works for both numeric and categorical variables but OSAT might return less rows than the input provided because they might have NA value.
- **anticlust**, at CRAN, divides the samples into similar groups, ensuring similarity by enforcing heterogeneity within groups (Papenberg and Klau 2020). Conceptually it is similar to the clustering method k-means.
anticlust does not handle all types of variables, it only accepts numeric variables.
- Recently, **Omixer**, a new package, has been made available at Bioconductor (Sinke, Cats, and Heijmans 2021). It tests whether the random assignments made by it are homogeneous by transforming all variables to numeric values and using the Kendall's correlation when there are more than 5 samples; otherwise, it utilizes the Pearson's chi-squared test.
There is a bug in the Omixer that prevents it from working unless specific conditions are met. This precluded any comparisons of Omixer with other tools using the same settings.

For completeness a description and comparison of the usage of the different software packages currently available on CRAN and Bioconductor is presented below. First, we start with some real data obtained from a survey. This data set has three variables of interest; Sex, Smoke and Age are a mix of categorical and numeric variables.

Statement of need

Current solutions for stratifying samples to reduce and control batch effect do not work for all cases. They are either specialized to a particular type of data, they omit some conditions that



are usually met, or they only work under a specific subset of conditions. The new package ***experDesign*** works with all data types and does not require a spatial distribution making it suitable for all kind of experiments. This package is intended for people needing a quick and easy solution that will provide reasonable suggestions on how to best distribute the samples for analysis.

Description

The package ***experDesign*** provides the function `design` to arrange the samples into multiple batches such that a variable's distribution remains homogeneous within each batch. Each batch is set to have some centrality and dispersion statistics to match as closely as possible with the original input design data. The statistics used are the mean, the standard deviation, the median absolute deviation, variables with no value number, the entropy and the independence of the categorical variables. With each iteration if the random distribution of the sample statistics for each batch has fewer differences vis-à-vis the original distribution than the last stored sample distribution then it replaces it as the best sample distribution. Upon completion of the iterations the best sample distribution is returned to the user.

Users can examine the following flowchart to decide what function(s) they need to use:

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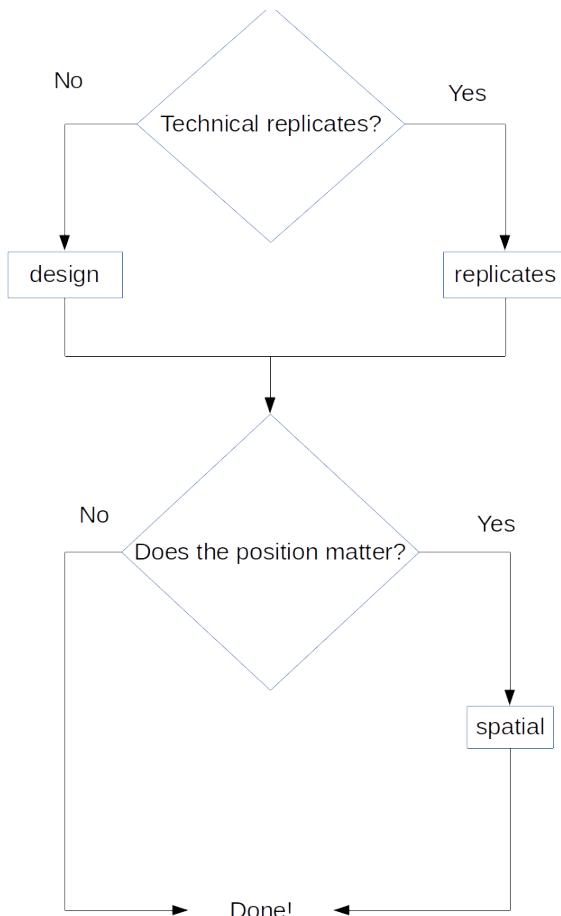


Figure 1: Flow chart to decide which functions are needed

If users want a design without replicates but the batches have some spatial distribution, we must use `design` to allocate the samples on each batch, followed by the `spatial` function to randomly distribute the samples homogeneously by position within each batch. See the example in `inspect` and the vignette:

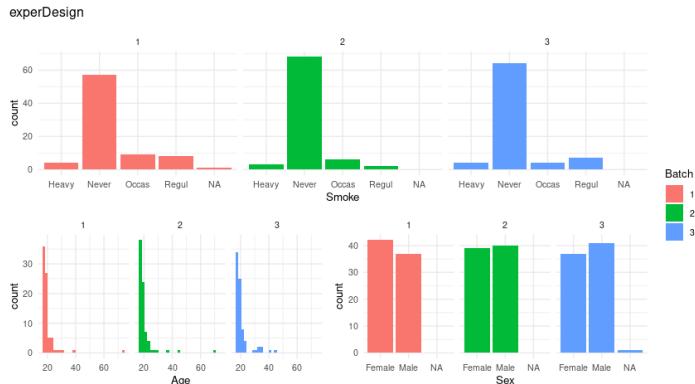
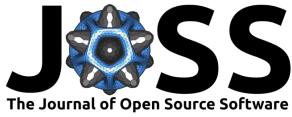


Figure 2: Example of distributions generated with `experDesign`.

On Figure 2 one can see that the distribution index generated by `experDesign` uses both numeric and categorical variables keeping also the samples with missing (NA) information.

The statistics of the index can be checked for multiple statistics, as shown on the help pages of `evaluate_na`, `evaluate_entropy`, `evaluate_mad`, `evaluate_sd` and `evaluate_mean`. We can also compare our results with the original distribution via `evaluate_orig`.

In addition to distributing the samples into batches, `experDesign` provides tools to add technical replicates. In order to choose them from the available samples, the function `extrem_e_cases` is provided. For easier usage, the `replicates` function designs an experiment with the desired number of replicates per batch.

`experDesign` also provides several small utilities to make it easier to design the experiment in batches. For instance, a function called `sizes_batches` helps calculate the number of samples in order to distribute them across the required batches. Furthermore, `optimum_batches` calculates the minimal number of batches required. Examples of all this methods can be found on the manual page of each function and on the vignette.

In conclusion `experDesign` offers a fast method for preparing a batched experiment. It can use as many numeric and categorical variables as needed to stratify the experimental design based on batches including spatial distributions.

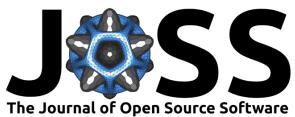
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References

- Blainey, Paul, Martin Krzywinski, and Naomi Altman. 2014. "Replication." *Nature Methods* 11 (9): 879–80. <https://doi.org/10.1038/nmeth.3091>.

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- Klaus, Bernd. 2015. "Statistical Relevancerelevant Statistics, Part i." *The EMBO Journal* 34 (22): 2727–30. <https://doi.org/10.15252/embj.201592958>.
- Leek, Jeffrey T., Robert B. Scharpf, Héctor Corrada Bravo, David Simcha, Benjamin Langmead, W. Evan Johnson, Donald Geman, Keith Baggerly, and Rafael A. Irizarry. 2010. "Tackling the Widespread and Critical Impact of Batch Effects in High-Throughput Data." *Nature Reviews. Genetics* 11 (10). <https://doi.org/10.1038/nrg2825>.
- Papenberg, Martin, and Gunnar W. Klau. 2020. "Using Anticlustering to Partition Data Sets into Equivalent Parts." *Psychological Methods*. <https://doi.org/10.1037/met0000301>.
- R Core Team. 2014. *R: A Language and Environment for Statistical Computing*. Vienna, Austria: R Foundation for Statistical Computing. <https://R-project.org/>.
- Sinke, Lucy, Davy Cats, and Bastiaan T Heijmans. 2021. "Omixer: Multivariate and Reproducible Sample Randomization to Proactively Counter Batch Effects in Omics Studies." *Bioinformatics*, no. btab159 (March). <https://doi.org/10.1093/bioinformatics/btab159>.
- Yan, Li, Changxing Ma, Dan Wang, Qiang Hu, Maochun Qin, Jeffrey M. Conroy, Lara E. Sucheston, et al. 2012. "OSAT: A Tool for Sample-to-Batch Allocations in Genomics Experiments." *BMC Genomics* 13 (1): 689. <https://doi.org/10.1186/1471-2164-13-689>.

Appendix D

Other datasets

D.1 BARCELONA dataset

All patients with an established diagnosis of IBD, including Crohn's disease, ulcerative colitis, unclassified IBD, indeterminate colitis, or pouchitis, starting treatment with a biologic agent were monitored following the schedule of clinical visits, laboratory tests, imaging procedures and biologic sampling at the beginning of their treatment with anti-TNF therapy and after 14 weeks and 46 weeks a biopsy from an ileocolonoscopy. The protocol was approved by the Institutional Ethics Committee of the Hospital Clinic de Barcelona (Study Number HCB/2012/7845 and HCB/2012/7956).

Patients that were referred to the Hospital Clínic de Barcelona IBD unit, who had already started treatment with a biologic agent in another center, were also included adapting to the corresponding time-schedule of their treatment. In all patients, starting anti-TNF treatment will be decided before the protocol entry decision according to medical clinical practice.

Anonymized identification of the patients, disease, sex age at diagnostic, age at the moment of the sample taking, time since the start of the treatment and sample segment was collected.

Table D.1: Samples included from the BARCELONA dataset characteristics.

Characteristic	BARCELONA
Individuals	62
Status (non-IBD/CD/UC)	8/33/21
Sex (female/male)	29/33
Age at diagnostic (<17/<40/>40 years)	2/44/8
Years of disease: mean (min-max)	7.6 (0-32)
Age: mean (min-max)	41 (18-68)
Time (0/14/46 weeks)	41/40/32
Sample segment (ileum/colon)	39/87

The process of DNA extraction and sequencing was different for this dataset. We used different 16S-V3V4 primers pair 341f/806r on a MiSeq Nano sequencing by the RTSF Genomics Core at Michigan State University, United State of America. The sequence of the primers used was:

341f: 5'-CCTACGGGAGGCAGCAG-3'
806r: 5'-GGACTACHVHHHTWTCTAAT-3'

The result of MiSeq Nano were processed with bcl2fastq (v1.8.4).

This dataset was processed as usual but as part of the quality controls of the dataset the diversity measures of the samples was analyzed on D.1:

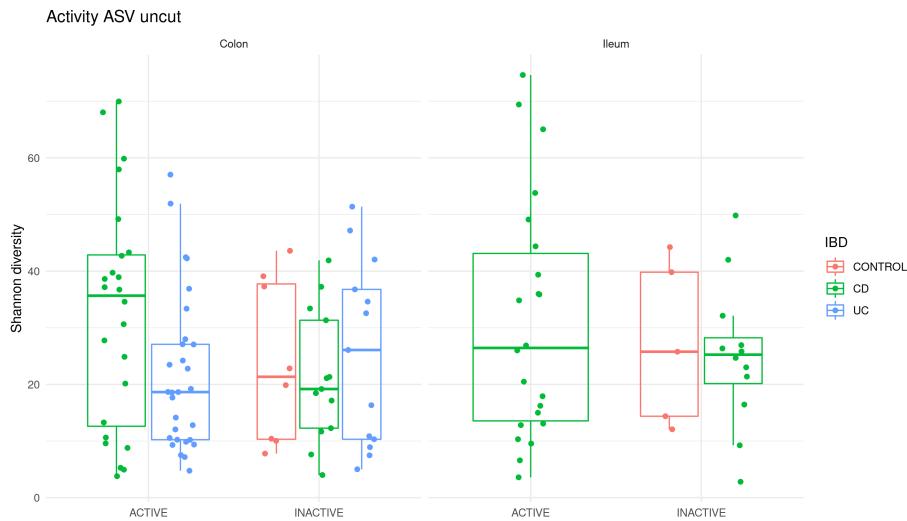


Figure D.1: Diversity indices of Barcelona according to the location and disease status. There is a lot of diversity between different groups but importantly the control samples overlap with the patients with inflammatory bowel disease.

Control samples diversity should be lower and not on the same range as with samples of patients with IBD. The dataset's 16S was sequenced several times by different platforms. Despite the pilots and the negative controls on the sequencing process, each time there were different problems: contamination, low quality and then this suspicious diversity. It does not seem to be a problem of the sequencing facility, so this data was abandoned as unreliable.

D.2 Hernández' dataset

This dataset was obtained from collaborators at Mount Sinai, Toronto, Canada [81].

Patients with UC, CD were recruited when attending regularly scheduled visits or surveillance. In addition, asymptomatic healthy controls (HC) were recruited

D.2. HERNÁNDEZ' DATASET

during routine, age-related colorectal cancer screening by colonoscopy. 290 samples were collected together with information about the disease, age at diagnosis, age at the moment of the sampling, sex, sample location and smoking status.

Table D.2: Characteristics of samples included from Hernández's dataset.

Characteristic	Hernández'
Disease (non-IBD/CD/UC)	46/54/66
Age at diagnostic (<17/<40/>40 years)	29/73/18
Age: mean (min-max)	40 (17-71)
Sex (female/male)	81/85
Smoking (never/ex/current)	115/34/16
Sample Location (ileum/colon)	97/193

D.2.1 Results

This dataset was processed to confirm the results on the previous datasets.

At the time of writing the process is not complete

Appendix E

Models output

E.1 HSCT

E.1.1 Genes

E.1.2 Microbiome

E.2 Häslер

E.2.1 Genes

E.2.2 Microbiome

E.3 Howell

E.3.1 Genes

E.3.2 Microbiome