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A Global Genome-wide Scan with Optimal Cutoff Mining for Emerging Biomarkers in Head and Neck Squamous Cell Carcinoma

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RESEARCH

A Global Genome-wide Scan with Optimal Cutoff Mining for Emerging Biomarkers in Head and Neck Squamous Cell Carcinoma

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Abstract

The survival analysis of the Cancer Genome Atlas (TCGA) dataset is a well-known method to discover the gene expression-based prognostic biomarkers of head and neck squamous cell carcinoma (HNSCC). In order to utilize a continuous gene expression for survival analysis, it is necessary to determine a cutoff point by the dichotomization of the patients. There is some optimization software for cutoff determination. However, those predetermined cutoffs by software usually set at the median, 1/4 quantile, or 3/4 quantile of RNA sequencing (RNA-Seq) value to find a significant P-value of the Kaplan-Meier curve. There are few clinicopathological features available on their pre-processed data sets.

We developed a comprehensive workflow by R script, running on the Rstudio platform. It includes data retrieving and pre-processing, feature selection, cutoff mining engine, Kaplan-Meier survival analysis, Cox proportional hazard modeling, and biomarker discovery. Using this workflow on TCGA HNSCC cohort, we scanned human protein-coding genes (20,500) programmatically and found that the surgical margin involvement (HR 1.601 [95% CI: 1.159-2.211, P-value = 0.004]) as well as tobacco exposure (HR 1.453 [95% CI: 1.055-2.000, P-value = 0.022]) are independent risk factors in patient survival. According to the resulting tables with Bonferroni adjusted P-value under optimal cutoff as well as hazard ratio ($>= 1.5$), there are ten candidate biomarkers, named as DKK1, CAMK2N1, STC2, PGK1, SURF4, USP10, NDFIP1, FOXA2, STIP1, and DKC1, which are significantly associated with the poor prognosis of overall survival (OS). Further validations are warranted.

Keywords: Head and Neck Squamous Cell Carcinoma; HNSCC; TCGA; RNA-sequencing; Survival Analysis; Optimal Cutoff; Biomarker; Tumor Type-agnostic Therapy; Immuno-Oncology; Targeted Therapy; Systemic Therapy; Surgical Margin; Tobacco; Rstudio

Introduction

Head and neck squamous cell carcinoma (HNSCC), including oral, oropharyngeal, and hypopharyngeal origin, is the fourth leading cancer causes of death for males in Taiwan[1]. The age-standardized incidence rate of HNSCC in males is 42.43 per 100,000 persons[2]. The treatment strategies of HNSCC are surgery alone, systemic

therapy with concurrent radiation therapy (systemic therapy/RT), or surgery with adjuvant systemic therapy/RT (according to National Comprehensive Cancer Network, NCCN Clinical Practice Guidelines in HNSCC, Version 2.2020)[3]. Despite the improvement in those interventions, the survival of HNSCC has improved only marginally over the past decade worldwide[4]. The critical advancement of targeted therapy and immuno-oncology should benefit from emerging prognostic biomarkers, which guide the development of modern systemic therapy.

Accumulative knowledge showed that some biomarkers have prognostic significance in HNSCC. For example, node-negative HNSCC patients with p53 overexpression were found to have lower survival[5]. Overexpression of hypoxia-inducible factor (HIF)-1 alpha[6] or Ki-67[7] was found to be correlated with poor response to radiotherapy of HNSCC. The epidermal growth factor receptor (EGFR)[8][9] and matrix metalloproteinase (MMP)[10] were found to be over-expressed to promote invasion and metastasis of HNSCC. From 2000 to 2006, the anti-EGFR antibody-drug (cetuximab) has been developed and combined with radiotherapy, known as bio-RT, to increase survival of unresectable locoregionally advanced disease[11]. The systemic therapy of cetuximab plus platinum-fluorouracil chemotherapy (EXTREME regimen) improves overall survival when given as first-line treatment in patients with recurrent or metastatic HNSCC[12][13]. It was approved by the US Food and Drug Administration (FDA) in 2008. In advance, the bio-RT could have proceeded with docetaxel, cisplatin, and 5-fluorouracil (short as Tax-PF) induction chemotherapy to overcome the radio-resistance of HNSCC[14].

However, Rampias and his colleagues suggested oncogenic HRAS mutations could mediate cetuximab resistance in systemic therapy of HNSCC via the EGFR/RAS/ERK signaling pathway[15]. After that, the EGFR tyrosine kinase inhibitor (TKI) was introduced to help cetuximab in 2018. The anti-tumor activity was observed in a phase 1 trial for HNSCC patients using cetuximab and afatinib, a TKI of EGFR, human epidermal growth factor receptor 2 (HER2), and HER4[16]. Other EGFR TKI, such as gefitinib, erlotinib, osimertinib, were also developed to treat advanced HNSCC. Although 90% of HNSCC has overexpression of EGFR, cetuximab has only 10% to 20% response rate on those patients. So far, cetuximab is still the only drug of choice with proven efficacy, which targeted the selected HNSCC patients[17].

Until the immuno-oncology era, immune-checkpoint inhibitor (ICI) was introduced since 2014 for treating HNSCC[18][19]. The ICI works on immune checkpoint molecules, which including programmed death 1 (PD-1), cytotoxic T lymphocyte antigen 4 (CTLA-4), T-cell immunoglobulin mucin protein 3 (TIM-3), lymphocyte activation gene 3 (LAG-3), T cell immunoglobin and immunoreceptor tyrosine-based inhibitory motif (TIGIT), glucocorticoid-induced tumor necrosis factor receptor (GITR) and V-domain Ig suppressor of T-cell activation (VISTA)[20]. The US FDA has approved the anti-PD-1 agents, pembrolizumab, and nivolumab, as a monotherapy for the platinum-treated patients of recurrent or metastatic HNSCC[21]. However, because of the complexity of immune-tumor interaction, ICI has not to guarantee the response to programmed death ligand 1 (PD-L1) expressed HNSCC[19]. According to the phase 3 KEYNOTE-048 study, PD-L1 is a validated biomarker used in clinical guidance for candidate selection of pembrolizumab[22][23].

In our previous proteomic study in 2017, thymosin beta-4 X-linked (TMSB4X) was reported to be related to tumor growth and metastasis of HNSCC[24]. It was also found by the subsequent investigations that TMSB4X engaged in tumor aggressiveness through epithelial-mesenchymal-transition (EMT) on pancreatic[25], gastric[26], colorectal[27], lung[28], ovarian[29] and melanoma[30] cancers. Thus, it might be suggested that TMSB4X is possible for tumor type-agnostic therapy[31] as a common biomarker crossing several types of cancer.

In summary, identifying predictive biomarkers for selecting standard-of-care or advanced systemic therapy[32] in HNSCC is crucial. However, there are three challenges of biomarker discovery from survival analysis, so far. Firstly, although TCGA genomics data were harmonized, there is unclean data, including null expressed genes, which over 50% of the cohort, should be manually investigated and cleaned. Second, we need to find a way to determine candidates from the expression level of 20,500 human protein-coding genes[33]. Usually, the investigators should get the rationale or revelation of the genes of interest on a specific cancer type. They should upload those genes manually onto bioinformatics tools, such as SurvExpress (http://bioinformatica.mty.itesm.mx:8080/Biomatec/SurvivaX.jsp, which has been lost since Oct/2019 and currently out of funds), analyze with TCGA cohort. After downloading the survival results, they could curate plots and tables carefully. It is not possible to scan the whole human protein-coding genome in this way. Third, we need to find an optimal cutpoint of those RNA expression data to maximize candidate mining coverage. The above mentioned online tools might set a cutpoint at the median, 1/4 quantile, or 3/4 quantile for subsequent analyses. There are several visualization software or R packages which deal with cutoff determination, such as Prognoscan[34], Cutoff Finder[35], Findcut[36], Human protein atlas[37], OptimalCutpoints[32], cutpointr (available at https://github.com/thie1e/cutpointr), and cutoffR (available at https://cran.r-project.org/web/ packages/cutoffR). However, non of them could combine the scanning of the protein-coding genes and cutoff optimization programmatically.

In our approach, this article described a comprehensive workflow by R script, which runs on the Rstudio server. Its functions include data retrieving and preprocessing, feature selection, cutoff mining engine, Kaplan-Meier survival analysis, Cox proportional hazard modeling, and biomarker selection. Using this workflow on the TCGA HNSCC cohort, the 20,500 human protein-coding genes were scanned. The analysis workflow is shown in Figure 1.

Materials and Methods

Patient Cohort

The Cancer Genome Atlas (TCGA) profiled 528 HNSCC clinical and genomic data, which has been standardized and available on a unified data portal, Genomic Data Commons (GDC) of the National Cancer Institute (NCI). GDC is available on https://portal.gdc.cancer.gov/projects/TCGA-HNSC. TCGA offers several computational tools to the public for facilitating cancer research. Broad Genome Data Analysis Center (GDAC) Firebrowse (firebrowse.org, version 1.1.35, 2016_09_27) is one of those tools to provide data access to each TCGA disease through a Representational State Transfer (REST) Application Programmable Interface (API).

The 528 TCGA HNSCC patients' clinical information and RNA-Seq data were obtained from the Firebrowse RESTful API with an R package, FirebrowseR (available at https://github.com/mariodeng/FirebrowseR)[38]. We utilized FirebrowseR with our analysis workflow (see Figure 1) to receive standardized data frames while avoiding data re-formatting, often causing some errors.

RNA Sequencing Data

The number of protein-coding genes was suggested as 20,500[33]. The GDC Data Portal provided TCGA data has been harmonized and re-aligned RNA sequencing data against an official reference genome build GRCh38. RNA-Seq expression level read counts produced by Illumina HiSeq have been normalized using the Fragments per kilobase per million reads mapped (FPKM) method, as described in reference[39]. The RNA-Seq preprocessor of Broad GDAC picked the "RNA-Seq by Expectation-Maximization" (RSEM) value from Illumina HiSeq/GA2 mRNAseq level_3 (v2) dataset of NCI GDC. It made the mRNAseq matrix with log2 transformed for the downstream analysis, as described in their reference[40]. We utilized FirebrowseR's function call, Samples.mRNASeq(cohort = "HNSC", gene=GeneName, format="csv"), to download each RNA-Seq data of all HNSCC patients and to save as 20,499 data frame files, named as "HNSCC.mRNA.Exp.[GeneName].
Fire.Rda". After careful investigation of the genomic dataset, the RNA-Seq values of "SLC35E2A" and "SLC35E2B" should be considered two distinct expression entities. We concluded that the number of protein-coding genes in the TCGA dataset is 20,500. We removed null expressed genes, which over 50% of the cohort, to avoid the useless result.

Clinical Data

We utilized FirebrowseR's function call, Samples.Clinical(cohort = "HNSC", format="csv"), to get all 81 clinical features (including pathological data, defined by TCGA GDC data dictionary: Common Data Element, CDE[41]) of all 528 HNSCC patients, which saved as one data frame file: "HNSCC.clinical. Fire.Rda" (accessed November 2019).

One "HNSCC.clinical.Fire.Rda" tables and 20,500 "HNSCC.mRNA.Exp. [GeneName].Fire.Rda" tables were transposed and merged by their tcga _participant_barcode (unique patient ID) to yield a data frame with 528 rows (participants) against 20,581 columns (81 clinical features as well as 20,500 protein-coding RNA-Seq of cancer specimen). The clinicopathological features selected for our workflow included gender, age, clinical tumor size, clinical cervical lymph node metastases, clinical distant metastasis assessment, pathological surgical margin, and tobacco exposure with their corresponding survival data. The tumor size, cervical lymph node metastases, and distal metastasis status were classified according to the American Joint Committee on Cancer (AJCC)[42] along with the Union for International Cancer Control (UICC)[43] TNM system for clinical staging HNSCC. We made data clean by removing duplicated rows and columns.

Cutoff Finder Core Engine

To evaluate the effect of gene expression on the patient's survival, we introduced the stratifying of patients with Kaplan-Meier survival analysis according to each gene's low/high expression. Our cutofFinder_func engine employs the minimum P-value approach to recognizing cutoff points in continuous gene expression measurement for patients sub-population. First, patients were ordered by RNA-Seq value (RSEM) of a given gene. Next, patients were stratified at a serial cut (counted by person ranked in 30% to 70% percentile of the cohort). The survival risk differences of the two groups were estimated by log-rank test to yield around 165 Kaplan-Meier P-values for each gene. Then, the optimal cutoff of RNA-Seq, giving the minimum P-value, was selected by the cutofFinder_func subroutine. This iteration method could calculate all possible cutoff of each gene expression in this cohort. At each run of cutofFinder_func function call for an individual gene, it returned an optimal cutoff value (e.x. 0.027 for gene CAMK2N1). The optimal cutoff value and its correlated patient grouping size (e.x. low-expression in 262 persons vs. high-expression in 152 persons with gene CAMK2N1) allowed downstream Cox survival analysis. The percentile range we applied as 30% to 70% was used to avoid a small grouping effect[44][34]. In case there was no significant P-value, a median expression of this gene was set as its cutpoint as usual.

Statistical Consideration

Our workflow has loops to call function survival_marginSFP(GeneName) with given GeneName to process the survival analysis gene by gene. We dichotomized the clinicopathological features, which includes gender (male/female), age at diagnosed (below/beyond 65 year-old), clinical tumor size (T1-2/T3-4), clinical nodal status (negative/positive), clinical distant metastasis (negative/positive), TNM staging (early/late), surgical margin status (negative/positive) and tobacco exposure (low/high). The patients were grouped by an RNA-Seq value of each gene, cut at low- or high-expression on an optimal P-value obtained from the cutofFinder_func engine (see the section of "Cutoff Finder Core Engine"). Pearson's chi-square test was used for these binary variables. Kaplan-Meier survival was analyzed using the log-rank test for two groups OS comparison. The Cox proportional hazards regression is the widely accepted approach for modeling survival while accounting for confounding factors[45]. Univariate and multivariate Cox proportional regression model[46], using the "coxph" function in R package "survival", was applied to calculate hazard ratio, 95% confidence interval (95% CI) and its significance, and to estimate the independent contributions of each clinicopathological features to the OS. Results were considered statistically significant when a two-sided P-value < 0.05, or a lower threshold if indicated. There were multiple correlated tests in the family of Kaplan-Meier survival hypotheses during our global scanning of protein-coding genes. The stringent Bonferroni correction could result in an adjusted P-value to ensure the control for type I error.

The resulting data, including Kaplan-Meier curves, cumulative P-value plots, and Cox regression tables, were exported to ".xlsx" and ".Rda" files (by R package "r2excel") for subsequent biomarker selection.

Biomarker Selection

Those genes with prognostic impact, whose hazard ratio >= 1.5 or <= 0.5 in both Cox's univariate/multivariate model, were assigned as provisional candidates. Bonferroni adjusted (Kaplan-Meier) P-value was used to make a ranking of candidates for the final decision.

Results

The 9416 Kaplan-Meier plots with associated Cox's univariate and multivariate tables were generated at workflow step 1 (see Figure 1: "table generation") and justified by the ranking of hazard ratios. By uncorrected P-value below 0.05, we selected 967 genes in which HR is greater than 1.5 or less than 0.5 (see Figure 2A univariate, and Figure 2B multivariate plots). At the final step, a Bonferroni P-value correction was used to yield the twenty candidate genes, under the stringent criteria (see Figure 2C, D). The ten candidates, including DKK1, CAMK2N1, STC2, PGK1, SURF4, USP10, NDFIP1, FOXA2, STIP1, and DKC1, have significantly associated with the poor prognosis of overall survival (OS) (see Table 1), while the other ten genes were over-expressed in the better survival patients, named as ZNF557, ZNF266, IL19, MYO1H, FCGBP, LOC148709, EVPLL, PNMA5, KIAA1683, and NPB (see Table 3). We made a volcano plot for 9416 genes by Kaplan-Meier P-value (less than 0.05, obtained during cutoff finding procedure) against the Cox hazard ratio(see Figure 3). The plot revealed that the most significant (Bonferroni-adjusted P-value < 0.05) candidate genes are located above the dotted line. At the same time, Cox's HR separated them on the two-side with prognostic impact.

Our top 1 candidate is DKK1 (see Figure 4A). The Kaplan-Meier curve revealed 227 patients bearing the higher expression of DKK1 were suffered from only 40% of 5-year OS survival rate. In comparison, the other 187 patients with lower expression (the cutoff at -0.312(RSEM)) have been a better prognosis (adjusted P-value as 0.001). Figure 4B's cumulative P-value plot showed that the uncorrected 116 P-values (< 0.05) were estimated by s serial cut from 125 to 290 persons for grouping the cohort in our cutoff finding procedure (cutofFinder_func.R, see Figure 1 workflow diagram). The smallest P-value (8.9×10^{-8}), when cut on n=187 (45.2% of 414), was defined as optimal P-value. Conversely, the most associated gene with better survival is ZNF557. In Figure 4C, a Kaplan-Meier curve revealed 264 patients bearing the higher expression of ZNF557 have 55% of 5-year OS survival rate (adjusted P-value = 0.001). The cutoff finding procedure (cutofFinder_func.R) generated cumulative P-value plots in Figure 4D. There were 166 uncorrected P-values estimated by a serial cut from 125 to 290 for grouping the cohort. All was less than 0.05, and the smallest P-value (8.6×10^{-8}), when cut on n=150 (36.2% of total cohort 414), was defined as optimal P-value with a cutoff value -0.511(RSEM) of RNA-Seq.

Table 1, there were ten candidate genes over-expressed with poor prognosis in HNSCC, which was ranked by adjusted Kaplan-Meier P-value. We found their Cox's univariate and multivariate HR are all greater than 1.837. There were few published articles of SURF4 and NDFIP1, which were related to cancer research. In Table 2, after adjustment of confounders, it was considered the DKK1 over-expression is the independent prognostic factor (multivariate HR 2.135 [95% CI: 1.559-2.924, P-value < 0.001]), as well as clinical T stage (HR 1.978 [95% CI: 1.046-3.737, P-value

= 0.036]) and surgical margins status (HR 1.601 [95% CI: 1.159-2.211, P-value = 0.004]). The age older than 65 year-old has negative influence on survival (HR 1.462 [95% CI: 1.078-1.983, P-value = 0.015]). The M stage could not be considered due to only 3 out of 414 patients which have distant metastasis.

There were also ten candidate genes over-expressed with a better prognosis of HNSCC, listed in Table 3. Cox's univariate and multivariate HR is just under 0.5. In Table 4, after adjustment of confounders, it revealed HR 1.961 [95% CI: 1.035-3.714, P-value = 0.039] in advance clinical T Status, HR 1.631 [95% CI: 1.18-2.254, P-value = 0.003] with positive surgical margin involvement, HR 1.453 [95% CI: 1.055-2.000, P-value = 0.022] with higher tobacco exposure, and a protective HR 0.499 [95% CI: 0.372-0.669, P-value < 0.001] in over-expressed ZNF557 gene.

In overall results, those 20 candidate biomarkers, clinical T stage, and surgical margin are independent prognosis factors in HNSCC.

Discussion

The comprehensive adverse features of prognosis in HNSCC should include ethnicity, alcohol consumption, radiation therapy, chemotherapy, targeted therapy, EGFR amplification, HPV status, positive/close surgical margin ($< 5mm$), extranodal extension (ENE), lymph-vascular space invasion (LVSI), perineural invasion (PNI), depth of invasion (DOI $> 5mm$), as well as metastatic lymph node density (LND)[47], and worst pattern of invasion score 5 (WPOI-5), which was defined as tumor dispersion $>= 1mm$ between tumor satellites or positive PNI/LVSI[42]. The features of lymph node density, DOI, LND, and tumor dispersion were not available on the TCGA dataset. The Brandwein-Gensler's risk model (lymphocytic host response, WPOI, and PNI)[48][49] was suggested to be routinely performed on pathological examination. Thus, in the current study, we selected the common clinicopathological features, including gender, age, clinical T, clinical N, clinical M, surgical margin status, and tobacco exposure in the biomarker discovery for adjustment of confonders (details description at Materials and Methods section).

In previous reports of HNSCC, the loco-regional failure will be high when the initial frozen section has a positive/close surgical margin, and even the final margin revision revealed negative[50]. According to Table 2 and Table 4 in our study, the positive surgical margin yielded a hazard ratio greater than 1.6 to influence on patient's overall survival. It was suggested by authors [51][52][53][54][55][56]citeShapiro2017[57][58][59] that the reason of positive/close surgical margin is possibly due to tumor aggressiveness or dispersion (WPOI-5) instead of iatrogenic reason of surgery. The surgical margin status is suggested as the other independent prognostic biomarker, which should not be ignored from the HNSCC study.

In our previous work, altered glucose metabolism (e.g., the Warburg effect[60]) promotes the progression of HNSCC, which is partially attributed to the SLC2A4 (or glucose transporters 4, GLUT4) and tripartite motif-containing 24 (TRIM24) pathway[61]. In this study, LOC148709 (a long non-coding RNA) was suggested as a biomarker of HNSCC (see Table 3). It was also found to has a contribution to the Warburg effect on esophagus cancer[62].

The success of pembrolizumab and nivolumab was based on a common biomarker (e.g., PD-1) crossing several types of cancer. It showed a precedent of tumor type-agnostic therapy[31]. Currently, there are several common biomarkers of ICI under evaluation, which include tumor-infiltrating lymphocytes (TIL), interferon gamma ($IFN-\gamma$), and tumor mutational burden (TMB)[23]. The other ICI, anti-LAG-3 (pelatlimab), is currently evaluated under the phase I/IIA[32](ClinicalTrials.gov Identifier: NCT01968109) and II-IVA[63](ClinicalTrials.gov Identifier: NCT04080804) studies.

We need such useful bioinformatics tools for global scanning of human protein-coding genes crossing several types of cancer to help develop common biomarker discovery.

Conclusion

Our findings suggested 20 candidate biomarkers, DKK1, CAMK2N1, STC2, PGK1, SURF4, USP10, NDFIP1, FOXA2, STIP1, DKC1, as well as ZNF557, ZNF266, IL19, MYO1H, FCGBP, LOC148709, EVPLL, PNMA5, KIAA1683, and NPB, are all heavily associated with the prognosis of overall survival (OS) under optimal cut-off points with stringent Bonferroni P-values. They also might be potential common biomarkers for subsequent study. We wish this analysis tool will be available for the broad usage of tumor-agnostic research[64] to cross several TCGA diseases in the future.

Data and R script Availability

All data process and analyses were performed with R programming language (https://www.r-project.org/, version 4.0.2 2020-06-22) and R packages "firebrowseR", "survival", "reshape", "data.table", "ggplot2", "R.utils", "xlsx", "r2excel", "rJava" and "rms" at Rstudio server (version 1.2.5001) based on Google cloud platform under operation system Linux (Ubuntu LTS, release v18.04.3). The R script codes and datasets generated during the current study are available in the GitHub repository, https://github.com/texchi2/pvalueTex.

Competing interests

The authors declare that they have no competing interests.

Author's contributions

A.T.H. Wu, Y.C. Li, and M. Hsiao designed and supervised the study, L.H. Chi conceived and conducted the experiment(s), L.H. Chi made the R coding and debugging, Y.C. Li and M. Hsiao analyzed the results. L.H. Chi, A.T.H. Wu and Y.C. Li are involved in manuscript writing, review, and revision. All authors reviewed the manuscript.

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Figures

Figure 1 A workflow of HNSCC biomarker discovery, step 1 (blue line: main procedure) and step 2 (orange line: analysis export). The "main procedure" includes data retrieving, process with cleaning, and survival analyses. Cutoff engine (cutofFinder_func.HNSCC.R) might calculate all possible Kaplan-Meier P-value to yield the optimal cutoff value of RNA-Seq for subsequent Cox modeling (please see Materials and Methods section for details). The step 2 "analysis export" performs dissecting and selection of candidate genes by Bonferroni adjusted P-value as well as a hazard ratio of Cox model.

Figure 2 HNSCC Cox's hazard ratio and P-value plots. (a) Univariate HR versus uncorrected P-value; (b) Multivariate HR versus uncorrected P-value; (c) Univariate HR versus Bonferroni corrected P-value; and (d) Multivariate HR versus Bonferroni corrected P-value.

Figure 3 Volcano plot of genes under survival analyses. X axis: unadjusted P-value of Kaplan-Meier survival (-log10 transformed). Y axis: multivariate hazard ratio from Cox proportional regression model. Dotted line: significant Bonferroni corrected P-value. Red circles mark 10 candidate genes, which impact on poor prognosis ($HR >= 1.5$). Green circles mark 10 genes, which affect on better survival ($HR <= 0.5$).

Tables

Figure 4 Kaplan-Meier survival analyses, by cutoff finding. (a) Kaplan-Meier plot of DKK1 under optimal P-value, and (b) the cutoff was derived from cumulative P-value plots of DKK1. (c) Kaplan-Meier plot of ZNF557 under optimal P-value, and (d) the cutoff was derived from cumulative P-value plots of ZNF557.

Table 1 The 10 candidate genes over-expressed with poor prognosis in HNSCC (ranked by Bonferroni adjusted P-value)

Gene ID	Gene Description	Kaplan-Meier survival		Univariate		Multivariate		Remark
		P-value	Adjusted P-value	HR*	95% CI	HR*	95% CI	
DKK1	dickkopf WNT signaling pathway inhibitor 1	8.9×10^{-8}	0.001	2.266	1.666-3.082	2.135	1.559-2.924	**
CAMK2N1	calcium/calmodulin-dependent protein kinase II inhibitor 1	2.9×10^{-7}	0.002	2.101	1.572-2.809	2.007	1.490-2.704	**
STC2	stanniocalcin 2	6.5×10^{-7}	0.004	2.147	1.578-2.921	2.075	1.515-2.843	**
PGK1	phosphoglycerate kinase 1	9.1×10^{-7}	0.006	2.127	1.563-2.895	2.046	1.498-2.795	**
SURF4	surfeit 4	9.6×10^{-7}	0.006	2.055	1.531-2.757	2.089	1.543-2.829	3
USP10	ubiquitin specific peptidase 10	1.7×10^{-6}	0.012	2.083	1.532-2.834	2.119	1.551-2.895	**
NDFIP1	Nedd4 family interacting protein 1	2.6×10^{-6}	0.017	2.031	1.502-2.746	2.027	1.483-2.771	6
FOXA2	forkhead box A2	2.7×10^{-6}	0.018	1.976	1.479-2.640	1.914	1.426-2.569	**
STIP1	stress-induced-phosphoprotein 1	4.3×10^{-6}	0.029	1.958	1.463-2.621	1.957	1.451-2.640	**
DKC1	dyskeratosis congenita 1, dyskerin	6.3×10^{-6}	0.042	2.046	1.490-2.808	1.837	1.332-2.534	**
Selection criteria: Kaplan-Meier Bonferroni adjusted P-value < 0.05¬† Cox's univariate and multivariate$HR >= 1.5$								
* Cox's model: P-value < 0.001								
Remark: number of articles related with cancer research; ** as many								

Table 2 Univariate/multivariate Cox's proportional hazards regression analyses on OS time of DKK1 gene expression in HNSCC

Features		Univariate			Multivariate		
		HR	CI95%	P-value	HR	CI95%	P-value
Gender	Female	1			1		
	Male	1.157	0.843-1.587	0.367	1.178	0.841-1.650	0.342
Age at diagnosis	$<= 65y$	1			1		
	$> 65y$	1.329	0.990-1.784	0.058	1.462	1.078-1.983	0.015
Clinical T Status	T1+T2	1			1		
	T3+T4	1.409	1.028-1.931	0.033	1.978	1.046-3.737	0.036
Clinical N Status	N0	1			1		
	N1-3	1.185	0.890-1.577	0.246	1.149	0.805-1.640	0.445
Clinical M Status	M0	1			1		
	M1	4.097	1.009-16.64	0.049	6.513	1.415-29.96	0.016
Clinical Stage	Stage I+II	1			1		
	Stage III+IV	1.245	0.882-1.759	0.213	0.597	0.277-1.287	0.188
Surgical Margin status	Negative	1			1		
	Positive	1.591	1.155-2.191	0.004	1.601	1.159-2.211	0.004
Tobacco Exposure	Low	1			1		
	High	1.364	1.008-1.844	0.044	1.302	0.943-1.797	0.109
RNA-Seq	Low	1			1		
	High	2.266	1.666-3.082	***	2.135	1.559-2.924	***
(P-value significant codes is denoted: $red < 0.05$; *** < 0.001)							

Table 3 The 10 candidate genes over-expressed with better prognosis in HNSCC (ranked by Bonferroni corrected P-value)

Gene ID	Gene Description	Kaplan-Meier survival		Univariate		Multivariate		Remark
		P-value	Adjusted P-value	HR*	95% CI	HR*	95% CI	
ZNF557	zinc finger protein 557	8.6×10^{-8}	0.001	0.465	0.348-0.619	0.499	0.372-0.669	0
ZNF266	zinc finger protein 266	2.2×10^{-7}	0.001	0.474	0.355-0.632	0.453	0.338-0.607	1
IL19	interleukin 19	3.7×10^{-7}	0.002	0.472	0.351-0.635	0.459	0.340-0.619	14
MYO1H	myosin 1H	3.8×10^{-7}	0.003	0.468	0.347-0.632	0.467	0.344-0.634	0
FCGBP	Fc fragment of IgG binding protein	1.2×10^{-6}	0.008	0.484	0.359-0.653	0.496	0.366-0.674	**
LOC148709	LncRNA LOC148709	1.5×10^{-6}	0.010	0.499	0.374-0.666	0.485	0.361-0.652	1
EVPLL	envoplakin-like protein	2.0×10^{-6}	0.013	0.490	0.363-0.661	0.494	0.364-0.672	0
PNMA5	paraneoplastic antigen like 5	2.6×10^{-6}	0.017	0.499	0.371-0.671	0.481	0.357-0.650	5
KIAA1683	IQCN, IQ Motif Containing N	3.1×10^{-6}	0.020	0.500	0.371-0.673	0.483	0.356-0.654	0
NPB	neuropeptide B	4.0×10^{-6}	0.027	0.460	0.328-0.646	0.457	0.324-0.646	4

Selection criteria:
Kaplan-Meier Bonferroni adjusted P-value < 0.05
Cox's univariate and multivariate HR $>= 1.5$
Cox's model: P-value < 0.001
Remark: number off articles related to cancer research; ** as many
lncRNA: Long non-coding RNA

Table 4 Univariate/multivariate Cox's proportional hazards regression analyses on OS time of ZNF557 gene expression in HNSCC

Features		Univariate			Multivariate		
		HR	CI95%	P-value	HR	CI95%	P-value
Gender	Female	1			1		
	Male	1.157	0.843-1.587	0.367	1.163	0.833-1.625	0.375
Age at diagnosis	$<= 65y$	1			1		
	$> 65y$	1.329	0.990-1.784	0.058	1.328	0.976-1.808	0.071
Clinical T Status	T1+T2	1			1		
	T3+T4	1.409	1.028-1.931	0.033	1.961	1.035-3.714	0.039
Clinical N Status	N0	1			1		
	N1-3	1.185	0.890-1.577	0.246	1.179	0.824-1.686	0.367
Clinical M Status	M0	1			1		
	M1	4.097	1.009-16.64	0.049	8.478	1.847-38.92	0.006
Clinical Stage	Stage I+II	1			1		
	Stage III+IV	1.245	0.882-1.759	0.213	0.512	0.239-1.096	0.085
Surgical Margin status	Negative	1			1		
	Positive	1.591	1.155-2.191	0.004	1.631	1.180-2.254	0.003
Tobacco Exposure	Low	1			1		
	High	1.364	1.008-1.844	0.044	1.453	1.055-2.000	0.022
RNA-Seq	Low	1			1		
	High	0.465	0.348-0.619	***	0.499	0.372-0.669	***
(P-value significant codes is denoted: $red < 0.05$; *** < 0.001)							

Figure1

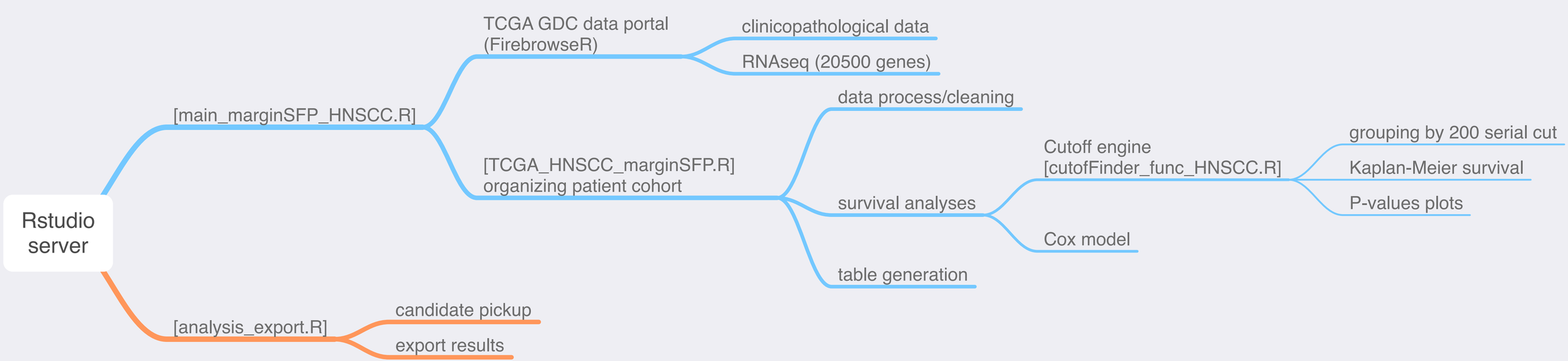

Figure2

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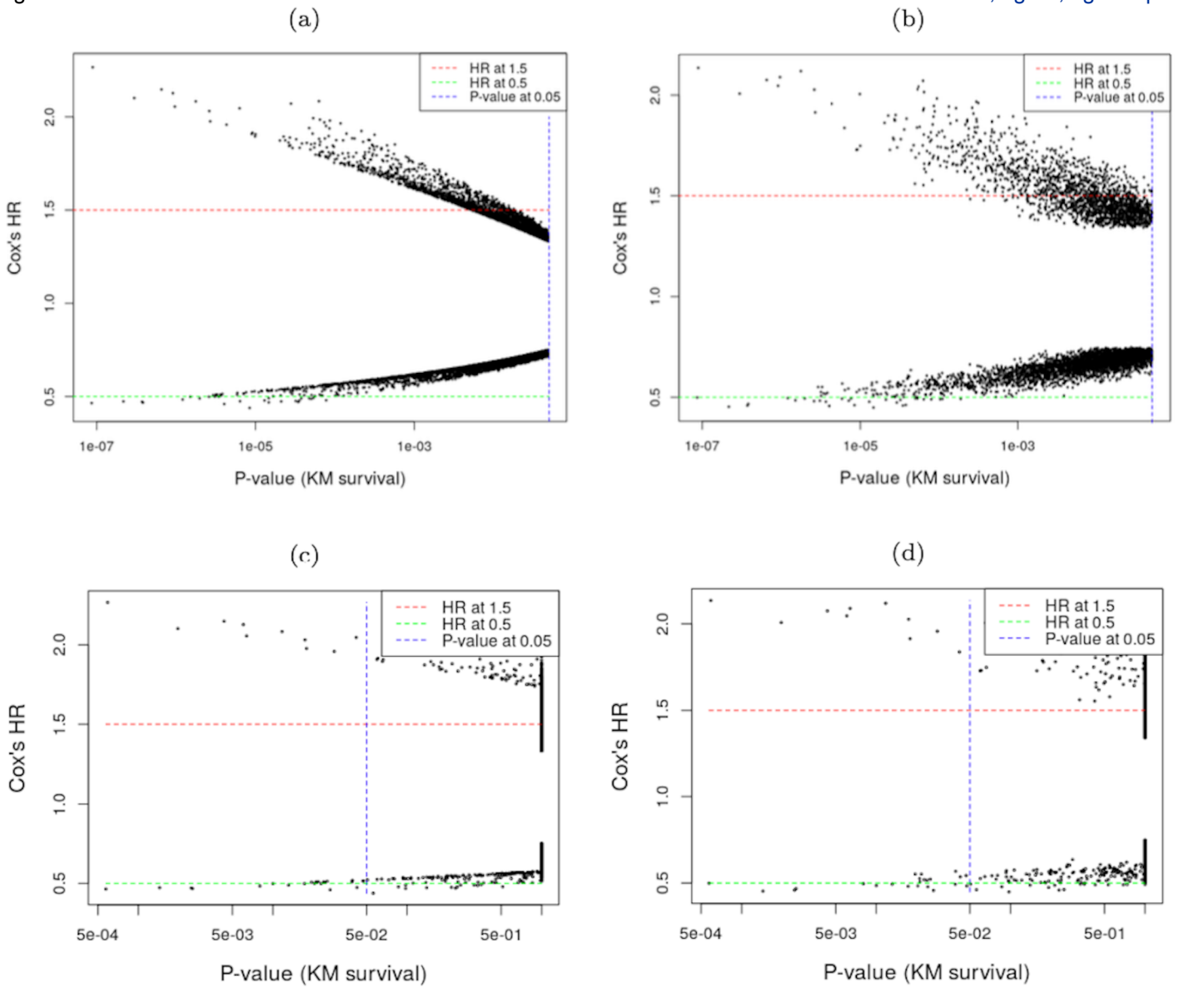

Figure3

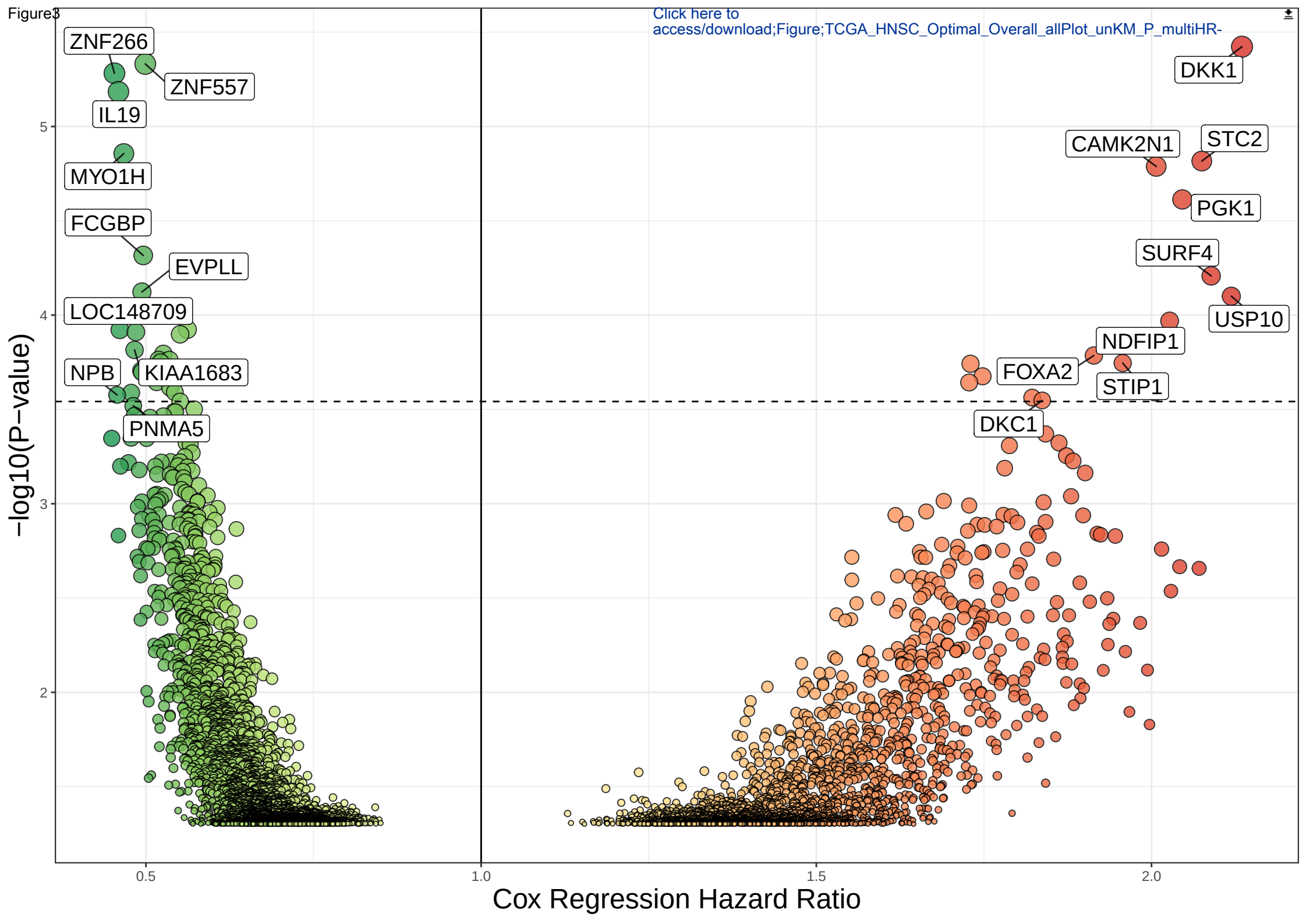
Click here to access/download;Figure;TCGA_HNSC_Optimal_Overall_allPlot_unKM_P_multiHR-
ZNF266
ZNF557
IL19
MYO1H
FCGBP
EVPLL
LOC148709
NPB
KIAA1683
PNMA5
DKK1
CAMK2N1
STC2
PGK1
SURF4
USP10
NDFIP1
FOXA2
STIP1
DKC1
5
4
3
2
−log10(P−value)
0.5
1.0
1.5
2.0
Cox Regression Hazard Ratio

Figure4

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