Next-Gen Sequencing Exposes Frequent MED12 Mutations and Actionable Therapeutic Targets in Phyllodes Tumors

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Abstract

Phyllodes tumors are rare fibroepithelial tumors with variable clinical behavior accounting for a small subset of all breast neoplasms, yet little is known about the genetic alterations that drive tumor initiation and/or progression. Here targeted next generation sequencing (NGS) was used to identify somatic alterations in formalin fixed paraffin embedded (FFPE) patient specimens from malignant, borderline and benign cases. NGS revealed mutations in mediator complex subunit 12 (MED12) affecting the G44 hotspot residue in the majority (67%) of cases spanning all three histological grades. In addition, loss-of-function mutations in p53 (TP53) as well as deleterious mutations in the tumor suppressors retinoblastoma (RB1) and neurofibromin 1 (NF1) were identified exclusively in malignant tumors. High-level copy number alterations (CNAs) were nearly exclusively confined to malignant tumors, including potentially clinically actionable gene amplifications in IGF1R and EGFR. Taken together, this study defines the genomic landscape underlying phyllodes tumor development, suggests potential molecular correlates to histologic grade, expands the spectrum of human tumors with frequent recurrent MED12 mutations, and identifies IGF1R and EGFR as potential therapeutic targets in malignant cases.

Implications:

Integrated genomic sequencing and mutational profiling provides insight into the molecular origin of phyllodes tumors and indicates potential druggable targets in malignant disease.
**Introduction**

Phyllodes tumors of the breast are relatively rare fibroepithelial tumors that account for approximately 1% of all breast neoplasms. Like benign breast fibroadenomas they are characterized by proliferation of both stromal and epithelial components, but in contrast they have considerable malignant potential. Phyllodes tumors are classified as benign (~65%), borderline (~25%) and malignant (~10%) based on histological features including cellular atypia, mitotic activity, stromal overgrowth, stromal cellularity and tumor margins(1). However, this histopathological classification often fails to predict which phyllodes tumors will recur or metastasize after treatment and does not accurately inform on treatment options. While local recurrence after resection is most prevalent in histologically malignant cases (approximately 30%, depending on width of excised margins), borderline and benign tumors can also recur locally in about 15% and 10% of cases, respectively, demonstrating the limitations of current prognostic approaches(2). Likewise, while ~10% of all phyllodes tumors progress to distant metastases, only ~20% of histologically malignant cases do so(3, 4), leaving a substantial number of borderline and even histologically benign cases that have metastatic potential. Conversely, although most histologically benign cases will behave as such, there are a proportion of phyllodes tumors classified as malignant and borderline that will behave in a benign manner. Current treatment guidelines for phyllodes tumors require wide surgical resection margins, but efficacious treatment options for the 10% of all phyllodes tumors that progress to metastatic disease are lacking and survival rates are dismal(3).

The key genetic alterations driving phyllodes tumor development and molecular correlates to histologic grade and malignant behavior are poorly characterized. Comparative genomic hybridization (CGH) and array CGH (aCGH) studies have shown multiple recurrent, broad somatic chromosomal copy number alterations (CNA) in phyllodes tumors, including...
gains of chromosome 1q and losses in 13q, 6q, 9p, however their prognostic utility is unclear (5-9). Several genes have been implicated in phyllodes tumor development by virtue of being localized to areas of CNA, including EGFR, which was recently shown by fluorescence in situ hybridization (FISH) to be amplified in 2-16% of cases (10, 11). In addition, gene expression and IHC studies have implicated various signaling pathways, including IGF and Wnt/β Catenin as being activated in phyllodes tumors (1). To more comprehensively assess somatic molecular alterations in phyllodes tumors and identify potential opportunities for personalized medicine, we performed next generation sequencing (NGS) of 15 formalin fixed paraffin embedded (FFPE) phyllodes tumors representing the histologic grade spectrum.

Materials and Methods

Case Selection

We identified a cohort of 15 archived, routine clinical FFPE phyllodes tumor specimens from the University of Michigan Department of Pathology Tissue Archive. Clinicopathological information for each case was obtained from the clinical archive. Hematoxylin and eosin (H&E) stained slides for all cases were reviewed by a board-certified Anatomic Pathologist (S.A.T.) to ensure sufficient tumor content and confirm histologic grade.

Targeted Next Generation Sequencing

Targeted next generation sequencing of tumor tissue was performed with IRB approval. For each specimen, 4-10 x 10um FFPE sections were cut from a single representative block per case, using macrodissection with a scalpel as needed to enrich for at least 50% tumor content (as
defined by areas of stromal overgrowth). DNA was isolated using the Qiagen Allprep FFPE DNA/RNA kit (Qiagen, Valencia, CA), according to the manufacturer’s instructions except for adding a 2 minute room temperature incubation and extending centrifugation time to 5 minutes during the xylene deparaffinization (step 1) and ethanol washing of xylene (step 2). DNA was quantified using the Qubit 2.0 fluorometer (Life Technologies, Foster City, CA).

Targeted, multiplexed PCR based next generation sequencing (NGS) was performed on each component using a custom panel comprised of 2,462 amplicons targeting 126 genes and Ion Torrent based sequencing. Genes included in this panel were selected based on pan-cancer NGS and copy number profiling data analysis that prioritized somatic, recurrently altered oncogenes, tumors suppressors, genes present in high level copy gains/losses and known/investigational therapeutic targets. Barcoded libraries were generated from 20ng of DNA per sample using the Ion Ampliseq library kit 2.0 (Life Technologies, Foster City, CA) according to manufacturer’s instructions with barcode incorporation. Templates were prepared using the Ion PGM Template OT2 200 Kit (Life Technologies, Foster City, CA) on the Ion One Touch 2 according to the manufacturer’s instructions. Sequencing of multiplexed templates was performed using the Ion Torrent Personal Genome Machine (PGM) on Ion 318 chips using the Ion PGM Sequencing 200 Kit v2 (Life Technologies, Foster City, CA) according to the manufacturer’s instructions.

Data analysis was performed essentially as described(12) in Torrent Suite 4.0.2, with alignment by TMAP using default parameters, and variant calling using the Torrent Variant Caller plugin (version 4.0-r76860) using default low-stringency somatic variant settings. Variants were annotated using Annovar(13). Called variants were filtered to remove synonymous or non-coding variants, those with flow corrected read depths (FDP) less than 20, flow corrected variant allele containing reads (FAO) less than 6, variant allele frequencies (FAO/FDP) less than
0.10, extreme skewing of forward/reverse flow corrected reads calling the variant (FSAF/FSAR <0.2 or >5, or FSAF or FSAR <3), or indels within homopolymer runs >4. Variants occurring exclusively in reads containing other variants (single nucleotide variants or indels) or those occurring in the last mapped base of a read were excluded. Variants with allele frequencies >0.5% in ESP6500 or 1000 genomes or those reported in ESP6500 or 1000 genomes with observed variant allele frequencies between 0.40 and 0.60 or >0.9 were considered germ line variants. High confidence somatic variants passing the above criteria were then visualized in IGV. We have previously confirmed that these filtering criteria identify variants that pass PCR validation with >95% accuracy (12). To prioritize potential driving alterations, we utilized Oncomine software tools (powertools.oncomine.com) to annotate called variants, which uses pan-cancer NGS data to identify genes as oncogenes or tumor suppressors, based on over-representation of hot-spot or deleterious mutations, respectively. Variants in oncogenes are then considered gain of function if at a hot-spot and variants in tumor suppressors are considered loss of function if deleterious or at a hot-spot (S.A.T. et al., manuscript in preparation).

**Copy number analysis**

To identify copy number alterations, normalized, GC-content corrected read counts per amplicon for each sample were divided by those from a pool of normal male genomic DNA samples (FFPE and frozen tissue, individual and pooled samples), yielding a copy number ratio for each amplicon. Gene-level copy number estimates were determined by taking the coverage-weighted mean of the per-probe ratios, with expected error determined by the probe-to-probe variance(12); a detailed manuscript describing this technique is in submission (C.S.G. et al.).
Genes with a log2 copy number estimate of <-1 or >0.6 were considered to have high level loss or gain, respectively.

**Sanger sequencing to validate called somatic variants**

Bi-directional Sanger sequencing was performed over the observed *MED12* mutation hotspot (G44) on all tumor samples. Ten nanograms of genomic DNA was used as template in PCR amplifications with Invitrogen Platinum PCR Supermix Hi-Fi (Life Technologies, Foster City, CA) with the suggested initial denaturation and cycling conditions. Primer sequences were as previously reported (14, 15) with the addition of universal M13 adaptors (M13 forward: TGTAAAACGACGGCCAGT and M13 reverse: CAGGAAACAGCTATGACC). PCR products were subjected to bidirectional Sanger sequencing for both primer pairs by the University of Michigan DNA Sequencing Core after treatment with ExoSAP-IT (GE Healthcare) and sequences were analyzed using SeqMan Pro software (DNASTAR, Madison, WI).

**qPCR to validate copy number variations**

*EGFR, IGF1R* and *CDKN2A* copy number changes were subjected to validation through quantitative real-time PCR (qPCR) for 12 samples with sufficient DNA. PH13, 14 and 30 had insufficient DNA (no copy number alterations in these genes were identified by NGS) for qPCR and PH5 had sufficient DNA only for assessing *EGFR* and *CDKN2A* (no *IGF1R* copy number alterations were identified by NGS). Primers and probes (5’ FAM; ZEN/Iowa Black FQ dual quenchers) were designed using PrimerQuest (http://www.idtdna.com/Primerquest/Home/Index, hg 19 genome assembly) and obtained from IDT. Assay specificity was confirmed using BLAST and BLAT and primers/probes in areas of SNPs were excluded. Primer/probes sequences are
available upon request. qPCR reactions (15ul) were performed in triplicate using TaqMan Genotyping Master Mix (Applied Biosystems), 5ng genomic DNA per reaction and a final concentration of 0.9uM each primer and 0.25uM probe in 384 well plates on the QuantStudio 12K Flex (Applied Biosystems). Automatic baseline and C\textsubscript{t} thresholds were set using QuantStudio 12K Flex Real-Time PCR System Software. Log\textsubscript{2} copy number of \textit{EGFR}, \textit{CDKN2A} and \textit{IGF1R} were determined by the ΔΔCT method using the average \textit{C}\textsubscript{t} of \textit{DNMT3A}, \textit{FBXW7} and \textit{MYO18A} as the reference (copy number neutral by NGS in all PH samples) and PH 22 (copy number neutral by NGS) as the calibrator sample.

**Statistics**

Comparisons of the number of mutations or copy number alterations per sample by tumor grade were performed using the Kruskal-Wallis test with post-hoc pairwise comparison of subgroups using MedCalc 13.1.2.0. Comparison of the frequency of \textit{MED12} mutations by tumor grade was performed by the Fisher’s exact test using R 3.1.0.

**Results**

We performed targeted NGS on a cohort of 15 FFPE phyllodes tumors comprised of 5 cases each of benign, borderline and malignant histological grade; representative photomicrographs and clinical characteristics of all patients are presented in Figure 1A. We isolated an average of 0.65ug DNA per case from 4-10 x 10um sections using macrodissection to enrich tumor content as needed. NGS was performed using a multiplexed PCR based custom Ion Torrent Ampliseq panel comprised of 2,462 amplicons targeting 126 genes and Ion Torrent based sequencing on the PGM. Targeted genes were selected based on pan-cancer NGS and copy
number profiling data analysis to prioritize somatic, recurrently altered oncogenes, tumors suppressors and genes present in high level CNAs. Detailed characterization of this panel will be reported separately (S.A.T. et al., manuscript in preparation).

NGS of multiplexed templates on the Ion Torrent PGM generated an average of 1,011,571 mapped reads yielding 409x targeted base coverage across the 15 samples (Table S1). We identified a total of 26 high-confidence, likely somatic non-synonymous or splice site altering point mutations and short insertion/deletions (indels) across the 15 samples (median 2, range 0-4) as shown in Tables S2&3. The number of high confidence somatic non-synonymous mutations were not significantly different between the histologic grades (Kruskal-Wallis test, p=0.09), as shown in Figure S1A. Copy number analysis of NGS data yielded a total of 16 high-level CNAs (median 0, range 0-6). The number of high level CNAs differed significantly between histologic grades (Kruskal-Wallis test, p=0.002), with malignant tumors harboring significantly more high-level CNAs per sample (median 2, range 2-6) than borderline (median 0, range 0-0) or benign (median 0, range 0-2) tumors (Kruskal-Wallis test, post-hoc analysis, both p<0.05 both), as shown in Figure S1B. Prioritized likely gain or loss of function somatic mutations in oncogenes and tumor suppressors (see below) and high level CNAs for each case are shown in an integrative heat map (Figure 1B).

By NGS, we found that MED12, which encodes subunit 12 of the Mediator complex (the multi-protein assembly that serves as a general co-activator of transcription by RNA polymerase II) was mutated in 10/15 samples (67%; one sample with biallelic mutations) by automated variant calling and visual read inspection in IGV (as some called variants were filtered due to skewed read support). All mutations were localized to the exon 2 hotspot region near residue G44 (Figure 2A & Table S2&3), which has recently been reported to be recurrently mutated at
high frequency in uterine leiomyomas(14-16) and benign breast fibroadenomas(17), and more rarely in uterine leiomyosarcomas(15, 16, 18, 19). Five of 11 total MED12 mutations were point mutations at G44 (3 p.G44S, 1 p.G44C, 1 p.G44R) while 3 mutations were frame-preserving deletions adjacent to or including G44 (p.38_43, p.41_49, p.42_51). Two mutations were intronic point mutations just upstream of exon 2, at a previously reported splice acceptor site causing retention of an additional 6 bases in the transcript (c.IVS-8 p.E33_D34insPQ)(14, 17). PH-11, which harbored a c.IVS-8 mutation, also harbored an additional intronic mutation further upstream (c.IVS-15), consistent with biallelic intronic MED12 mutations in this sample. There was no significant difference in the presence of MED12 mutations between tumors of different histologic grade (benign 4/5, borderline 4/5, malignant 2/5, Fisher's exact test, $p=0.5$). All MED12 mutations were confirmed by bidirectional Sanger sequencing (Figure 2B).

To prioritize potential driving alterations from the remaining non-MED12 point mutations/indels, we utilized the Oncomine Plugin in Ion Reporter for assessing gain or loss of function. This analysis identified five loss of function alterations, including three mutations in TP53 (F270L in PH-14, Q192X in PH-16 and C242Y in PH3), and one mutation each in RB1 (E533X in PH16) and NF1 (p.1152_1153del in PH-05), as shown in the integrative heat-map of driving alterations (Figure 1B & Table S2&3). Intriguingly, these loss of function alterations occurred exclusively in malignant tumors.

Copy number analysis of NGS data demonstrated recurrent low level CNAs, including gain of chromosome 1q and loss of chromosome 13q, consistent with previous reports(5-9). These were more prevalent in malignant tumors (5/5) but were also present in two borderline and one benign case (Figure 3A & S2). High level CNAs were nearly exclusively present in malignant specimens 14 of 16 alterations), as shown in Figure 3A&B. Of note, PH-03 showed
high level *EGFR* (copy number ratio > 6) and *IGF1R* amplifications, while PH-16 also showed a high-level *IGF1R* amplification (copy number ratio > 32, **Figure 3B**). *TERT* amplifications were also observed in three malignant tumors, while PH-05 harbored a focal high level *CDKN2A* (*p16INK4A*) loss. We confirmed *EGFR*, *IGF1R* and *CDKN2A* CNAs by quantitative real-time PCR (qPCR) as shown in **Figure 3C**.

**Discussion**

We performed targeted NGS of 15 FFPE phyllodes tumors representing all three histological grades to identify somatic alterations associated with tumor development and potential targetable alterations. Mutations in *MED12* were present in 10 of 15 cases (67%) and affected the known exon 2 G44 residue hotspot through multiple mechanisms. No significant difference in *MED12* mutation frequency was observed across histologic grades, although our cohort size is limited. Our IRB approved protocol does not allow NGS of matched normal tissue, however the observed *MED12* variant allele frequencies are consistent with somatic events as seen in other tumors. Similar *MED12* somatic mutations are frequent (50-70%) in benign uterine leiomyomas(14-16) but less common in malignant uterine leiomyosarcomas (7-30%)(15, 16, 18, 19). Recently, Lim *et al* identified similar *MED12* mutations in 59% of benign breast fibroadenomas through exome sequencing(17). Given the morphological similarity of breast fibroadenomas and benign phyllodes tumors, frequent *MED12* mutations in both entities support a closely related molecular origin. Additionally, although our findings will need to be replicated in larger cohorts, the similar frequency of *MED12* mutations across the histologic spectrum of phyllodes tumors (in addition to benign fibroadenomas) suggests that *MED12* mutations in the breast are early events which may be unrelated to malignant behavior, in contrast to uterine
leiomyomas and leiomyosarcomas, which show notable differences in \textit{MED12} mutation frequencies as just described. Our results also support the evolution of malignant phyllodes tumors from less aggressive fibroadenomas or phyllodes tumors (possibly through loss of key tumor suppressors). Although \textit{MED12} hotspot mutations have been identified infrequently in extrauterine or extramammary tumors\cite{18, 20}, functional studies support a role for \textit{MED12} mutations impacting the G44 hotspot in dysregulation of estrogen signaling in estrogen responsive cells\cite{17} and the Mediator complex is known to interact with the estrogen receptor\cite{21}.

Although surgical resection of phyllodes tumors may be curative, local recurrence is not uncommon and distant metastasis is associated with poor survival. Furthermore, the histological features do not accurately predict clinical behavior of phyllodes tumors. Hence, targetable alterations, particularly in malignant phyllodes tumors, may be useful for personalized medicine strategies. Through copy number analysis of NGS data (and confirmed by qPCR), we identified potentially clinically actionable high-level, focal amplifications of \textit{EGFR} and \textit{IGF1R} in 7 and 13\% of cases respectively (1/5 and 2/5 malignant cases). \textit{EGFR} has been shown to be highly amplified in phyllodes tumors by FISH in up to 16\% of cases\cite{10, 11}, consistent with our findings. Dysregulation of the IGF pathway has been implicated in phyllodes tumors by IHC\cite{1}, however \textit{IGF1R} amplification has not been reported.

Direct comparison of additional CNAs identified in our study and previous studies is challenging due to platform differences. However, broad, low-level gains in genes on 1q and losses on 13q were observed in malignant as well as borderline and benign tumors, consistent with previous reports. On the other hand, we did not observe gains in \textit{MDM2} or \textit{MDM4}, which have been reported in previous aCGH studies, and were targeted herein; we hypothesize this may
be due to the high $TP53$ alteration rate in our phyllodes tumors with high numbers of CNAs. Lastly, our panel did not target genes in some previously reported regions of CNA (such as 6q), precluding comparisons of these alterations.

Besides $MED12$ hotspot mutations, other potential driving somatic point mutations/indels, which included loss of function alterations in $TP53$, $RB1$ and $NF1$, occurred exclusively in malignant tumors. Additionally, high level, focal CNAs (such as those in $EGFR$ and $IGF1R$) were only observed in malignant cases. Together, these findings support molecular correlates to histologic grade. Whether such molecular alterations may be useful in cases with challenging histology or show prognostic potential can be investigated in additional cohorts.

Taken together, our results demonstrate frequent $MED12$ mutations in phyllodes tumors, supporting a shared origin with benign breast fibroadenomas. Additionally, our results suggest potential therapeutic targets in malignant tumors, including EGFR and IGF1R. Lastly, as both driving somatic mutations/indels other than $MED12$ and high level, focal CNAs occurred exclusively in malignant tumors in our cohort, such alterations may be useful for classification or prognostication in borderline tumors if confirmed in other cohorts.

Acknowledgments: The authors thank Javed Siddiqui and Mandy Davis for technical assistance.

Figure Legends:

Figure 1. Histology and clinicopathological information for formalin fixed paraffin embedded (FFPE) phyllodes tumors assessed by targeted next generation sequencing and integrative molecular heatmap of driving molecular alterations in phyllodes tumors.
A. Hematoxylin and eosin stained sections of representative benign (PH-19), borderline (PH-08) and malignant (PH-05 and PH-06) phyllodes tumors sequenced are shown. Top panels 4x original magnification; bottom panels 20x magnification. Clinicopathological information, including histologic grade, specimen type, patient age, procedure type and tumor size for all cases is given (Exc./Lump. = excisional biopsy or lumpectomy; Mast. = mastectomy; Core bx. = Core biopsy). B. Targeted next generation sequencing (NGS) of 15 formalin fixed paraffin embedded (FFPE) phyllodes tumors was performed to identify potentially driving/actionable molecular alterations. All high confidence, gain or loss of function somatic mutations in oncogenes and tumor suppressors, in addition to high level copy number alteration are indicated for each case. Specific alteration types are indicated according to the legend (Nonsyn. SNV = nonsynonymous SNV; Fs. and Fp. indel = frame-shifting and frame-preserving indels, respectively). Slashed boxes indicate two alterations. Clinicopathological information is shown above the heatmap according to the legend and as in Fig 1A.

Figure 2. Identification of recurrent MED12 mutations in phyllodes tumors. Next generation sequencing and Sanger sequencing identified 11 MED12 mutations in 10 of 15 phyllodes tumors subjected to next generation sequencing (NGS). A. Schematic representation of MED12 intron 1 and exon 2 junction with locations of all observed mutations shown. Mutation type is indicated in the legend and the frequency of observed mutations is indicated in parentheses. B. Bi-directional Sanger sequencing was performed on all specimens. Traces of cases with MED12 mutations are shown (only one trace direction shown) with the indicated nucleotide and amino acid changes noted. The mutation(s) position is indicated by the arrow.
Figure 3. Copy number analysis of phyllodes tumor identifies potential therapeutic targets in malignant samples. Copy number analysis was performed from next generation sequencing (NGS) data. For each sequenced phyllodes tumor, GC content corrected, normalized read counts per amplicon were divided by those from a composite normal sample, yielding a copy number ratio for each amplicon. Gene-level copy number estimates were determined by taking the weighted mean of the per-probe copy number ratios. A. Summary of gene level copy number ratios (log$_2$) for all profiled samples. Selected genes of interest with high level copy number alterations (CNAs) are colored according to the legend. B. Copy number profiles for three malignant phyllodes tumors with high level copy number alterations (CNAs). Log$_2$ copy number ratios per amplicon are plotted (with each individual amplicon represented by a single dot, and each individual gene indicated by different colors), with gene-level copy number estimates (black bars) determined by taking the weighted mean of the per-probe copy number ratios. Selected high level CNAs are indicated. C. Quantitative PCR (qPCR) confirmation of high level CNAs in *EGFR*, *IGF1R* and *CDKN2A*. qPCR on genomic DNA from indicated samples was performed using *DNMT3A*, *FBXW7* and *MYO18A* as the reference genes. Normalized mean *IGF1R* (blue), *EGFR* (red), and *CDKN2A* (green) log$_2$ copy number ratios (using PH22 [no CNAs by NGS] as the calibrator) from triplicate qPCR +/- S.D. are plotted.
References:


MEDical Landscape of Breast Phyllodes Tumors

Breast Phyllodes Tumors

Targeted Next Generation Sequencing

gagagactgatcagattgacagaca
tagagcaagactcaatctttgaccagaca
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actgcttctttgaccagaca
actgcttctttgaccagaca

Integrative Mutational Landscape

Grade
Type
Age
Tumor %

Disease Pathogenesis

Potential Therapeutic Targets

Benign
Malignant Potential

Breast
Fibroadenoma
Phyllodes Tumor

Uterus
Leiomyoma
Leiomyosarcoma

Frequent MED12 mutations
Infrequent MED12 mutations

Implications:
Integrated genomic sequencing and mutational profiling provides insight into the molecular origin of phyllodes tumors and indicates potential druggable targets in malignant disease.

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Molecular Cancer Research Rapid impact

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**Figure 1**

A) PH-19

B) PH-08

PH-05

PH-06

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Figure 3

A

B

C

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Molecular Cancer Research

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