The Telomere Length Landscape of Localized Prostate Cancer

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Abstract

Replicative immortality is a hallmark of cancer, and can be achieved through telomere lengthening and maintenance. We report telomere lengths (TLs) of 392 localized prostate cancer tumours and characterize their relationship to genomic, transcriptomic and proteomic features. Shorter tumour TLs were associated with elevated genomic instability, including single-nucleotide variants, indels and structural variants. Genes involved in cell proliferation and signaling were correlated with tumour TL at all levels of the central dogma. TL was also associated with multiple clinical features of a tumour. Longer TLs in non-tumour (blood) samples were associated with a lower rate of biochemical relapse after definitive local therapy. Our analysis integrates multi-omics data to illuminate the relationship of specific genomic alterations in a tumour and TL in prostate cancer. Although the role of telomere length in cancer has been well studied, its association to genomic features is less well known. We describe the multi-level integration of telomere length, genomics, transcriptomics and proteomics in localized prostate cancer. **Patient Summary** We examined the association between telomere length and multiple omics-level data in prostate cancer. We observed that traditional telomere mutations are rare in prostate cancer and that telomere length is associated with multiple measure of genomic instability.

Introduction

Telomeres, which make up the ends of chromosomes, consist of a repeat TTAGGG sequence[1] along with bound proteins known as shelterin[2]. Telomeres protect chromosomal ends from degradation by the DNA double-strand break (DSB) response pathway. Due to the linearity of chromosomes and chromosomal replication, telomeres are shortened by approximately 50 bp during mitosis[3]. When telomeres become substantially shortened, cell cycle progression halts and cells enter replicative senescence; further replication leads to cellular crisis and eventually cell death[4]. Telomere maintenance and lengthening is essential for cancer cell proliferation and enables replicative immortality: a fundamental hallmark of cancer[5]. Telomere regulation occurs through two known mechanisms: activation of telomerase or alternative lengthening of telomeres (ALT) which relies on homology-directed DNA replication[6].

Despite the pan-cancer studies analyzing the telomere length from various tumour types[7,8], the role of telomere maintenance in individual tumour types is poorly understand. Moreover, the relationship between telomere length and biologically-relevant genomic indices, such as percentage of the genome altered (PGA; [9,10], and other measures of mutational density has not been assessed, nor has the association between telomere length and clinical outcome in prostate cancer.

We and others have described the genomic, transcriptomic and proteomic landscape of localized, non-indolent prostate cancer[11–17]: the most frequently diagnosed non-skin malignancy in North American men (~250,000 new cases per year). Localized prostate cancer is a C-class tumour[18], characterized by a paucity of driver single nucleotide variants (SNVs) and a relatively large number of structural variants (SVs), including copy number aberrations (CNAs) and genomic rearrangements (GRs). Several of these aberrations, including mutations in *ATM* and amplifications of *MYC* – which drive DSB repair and cell proliferation, respectively – are associated with significantly reduced time to biochemical and metastatic relapse after local therapy[19]. Intriguingly, both of these mutations have also been associated with telomere maintenance[20,21] and telomere shortening – relative to adjacent epithelium[22]. Similarly an interaction between hypoxia, dysregulated *PTEN*, *TERT* abundance and telomere shortening was recently illustrated[14]. Despite this, no well-powered study exists evaluating the association between telomere length, somatic features and clinical outcome in prostate cancer.

To fill this gap, we quantify the telomere length and somatic mutational landscapes of 392 localized prostate tumours. We explore associations between telomere length and the tumour methylome, transcriptome and proteome. Using rich clinical annotation, we further assessed the relationship between telomere length and outcome. Taken together, these data establish the role and regulation of telomere length in localized prostate cancer, and establish clear links between telomere maintenance and drivers of prostate cancer development and clinical aggression.

Results

Association of telomere length with somatic nuclear driver events

To investigate the impact of telomere length (TL) on the clinico-genomics of prostate tumours, we exploited whole genome sequencing (WGS) of 392 published tumour-blood pairs[13–16]. We estimated both tumour and non-tumour (blood) TLs for each sample using TelSeq v0.0.1[23] and TelomereHunter[24]. After quality control, 381 samples were retained for further analysis (see **Methods**). All tumours were treatment-naive, and detailed clinical information was collected and is available in **Supplementary Table S1**. The cohort consisted of 11% ISUP Grade Group (GG) 1, 52% GG2, 33.5 % GG3, 6.8% GG4 and 3.4% GG5. For the majority of samples, the tumour was confined to the prostate (6.5% T1, 53.0% T2, 40.0% T3, 0.5% T4). The mean tumour coverage was 73.1x ± 20.6x; the mean non-tumour (blood) coverage was 44.1x ± 13.4x. Median clinical follow-up time was 7.46 years. TLs for each sample, along with clinical and genomic summary data are in **Supplementary Table S1**. Non-tumour (blood) TLs varied dramatically across individuals, ranging from 2.10 kbp to 15.0 kbp, with a median of 4.52 ± 1.35 kbp. By contrast, tumour TLs varied less but were significantly shorter, ranging from 1.03 kbp to 6.45 kbp with a median of 3.36 ± 0.87 kbp. Non-tumour (blood) TLs were not associated with sequencing coverage (**Supplementary Fig. S1A**). Tumour TLs were independent of tumour purity but there was a weak negative correlation between coverage and TL driven by some samples sequenced with over 100x coverage (**Fig. 1D**; **Supplementary Figs. 1A-B**). Tumour and non-tumour (blood) TLs estimates from TelSeq and TelomereHunter were highly correlated (**Supplementary Fig. S1C**). To account for batch effects, a linear model was fit and TLs were adjusted (**Supplementary Figs. S1D-E)**. TL ratios (tumour TL / non-tumour (blood) TL) were calculated to further reduce any effects caused by co-founding of age at diagnosis. Tumour and non-tumour (blood) TLs were positively correlated with one another ($\rho = 0.37$, $P = 7.30 \times 10^{-14}$, **Fig. 1A**). As expected, TL ratio was positively correlated with tumour TL ($\rho = 0.63$, $P < 2.2 \times 10^{-16}$; **Fig. 1B**) but negatively correlated with non-tumour (blood) TLs ($\rho = -0.40$, $P < 2.2 \times 10^{-16}$; **Figs. 1C**).

To assess whether tumour TL was related to any specific genomic property of a tumour, we evaluated a set of driver mutations previously identified in prostate cancer[13]. The relationship of each of these features with tumour TL is shown in **Fig. 1D**. While tumour TL was not associated with any known prostate cancer-related genomic rearrangement (GR) or single nucleotide variant (SNV) at current statistical power, samples with *CHD1*, *RB1* or *NKX3-1* deletions had shorter tumour TL (**Fig. 1D**). By contrast, TL was closely associated with multiple measures of genomic instability. Tumours with shorter TLs had an elevated number of SNVs ($\rho = -0.27$, $P = 5.78 \times 10^{-8}$; **Fig. 2A**), indels ($\rho = -0.32$, $P = 2.83 \times 10^{-10}$; **Fig. 2C**) and GRs ($\rho = -0.12$, $P = 1.6 \times 10^{-2}$; **Fig. 2E**), as well as higher

PGA (ρ = -0.21, P = 3.95 x 10^{-5}; **Fig. 2G**), suggesting tumours with shorter telomeres accrue more mutations of all types without strong selective pressures for specific ones.

To determine whether these associations with somatic features were also related to an individual's non-tumour (blood) cells, we related each somatic feature against the TL ratio (tumour TL / non-tumour (blood) TL). Similar to tumour TL, the TL ratio did not significantly differ between samples with any of the recurrent prostate cancer-related GRs or CNAs but samples with a somatic SNV in the gene *SPOP* had smaller TL ratios (**Supplementary Fig. S2)**. We identified significant correlations between somatic genomic instability measures and TL ratio. Tumours with an elevated number of SNVs (ρ = -0.15, P = 4.20 x 10^{-3}; **Fig. 2B**), indels (ρ = -0.18, P = 2.97 x 10^{-4}; **Fig. 2D**), GRs (ρ = -0.22, P = 1.08 x 10^{-5}; **Fig. 2F**) and PGA (ρ = -0.13, P = 1.69 x 10^{-2}; **Fig. 2H**) had smaller TL ratios.

We also assessed the association of telomere length with chromothripsis using published ShatterProof[25] scores from a subset of samples in this cohort (n = 170)[13]. There was no association between scores representing chromothripsis events in either tumour TL (ρ = 0.06, P = 0.43) or TL ratio (ρ = 0.02, P = 0.80).

Fusion events are associated with telomere length

When telomeres shorten beyond a certain length, double strand break repair is activated and cell cycle progression is arrested *via* the *TP53* pathway[26]. Failure to block cell growth can lead to telomere crisis and subsequent translocations, chromothripsis or chromosome fusions[27]. We explored the association of TL and the number of gene fusions present in a tumour. There was a negative correlation between the number of gene fusions and tumour TL (ρ = -0.26; P = 2.18 x 10^{-3}) but no correlation with TL ratio (**Figs. 2I-J**). In a previous study, 47 recurrent gene fusions were discovered from matched RNA-Sequencing data[17]. Differences in tumour TL and TL ratio between samples with a gene fusion and those without were investigated for each of these recurrent fusions. No gene fusions were associated with TL ratio, but PCAT1:CASC21 gene fusion was significantly associated with tumour TL (Mann Whitney U test; Q = 2.07 x 10^{-4}; **Supplementary Fig. S3** and **Supplementary Table S2**). Tumours with this fusion had shorter tumour telomeres (mean = 3.3 kbp) than those without (mean = 3.8 kbp). These data suggest that the number of fusions and specifically the long non-coding RNA *PCAT1*, which promotes cell proliferation, is related to tumour TL.

The role of *TERT* in prostate cancer

A pan-cancer study reported that *TERT* alterations including promoter mutations, amplifications and structural variants were seen in approximately 30% of all cancers[7]. In our cohort, 10% of samples had *TERT* amplifications, 11% had *TERC* amplifications, ~1% had *TERT* structural variants and no samples had *TERT* SNVs or gene fusions. *TERT* mutations were seen less frequently in other localized prostate cancer datasets, 1.7% (17/1,013; [28] and 0.6% (2/333; [12]), and in a metastatic dataset 3% (5/150; [19], likely

reflecting the early-stage of our cohort. Mutations in *ATRX* and *DAXX*, which have been correlated with longer telomeres[29], were rare in our cohort: only two samples harboured a CNA in *DAXX*, and only four samples had an alteration in *ATRX*.

Tumour *TERT* RNA abundance was not correlated with tumour TL or TL ratio (**Fig. 3A**). Samples with higher *TERT* RNA abundance had fewer GRs (ρ = -0.17; P = 4.79 x 10^{-2}; **Fig. 3B**), but there was no correlation between *TERT* abundance and SNV count (ρ = -0.04, P = 0.67; **Fig. 3C**), indel count (ρ = -0.04, P = 0.132; **Fig. 3D**) or PGA (ρ = -0.13, P = 0.679; **Fig. 3E**). The abundance of *TERC*, the telomerase RNA component, was negatively correlated with tumour TL (ρ = -0.24; P = 4.55 x 10^{-3}; **Supplementary Fig. 4A**) but there was no correlation with TL ratio or GR count (ρ = 0.12; P = 0.145; **Supplementary Fig. 4B**). *TERC* abundance was positively correlated with SNV count (ρ = 0.23; P = 7.34 x 10^{-3}; **Supplementary Fig. 4C**), indel count (ρ = 0.34; P = 4.88 x 10^{-5}; **Supplementary Fig. 4D**) and PGA (ρ = 0.26; P = 1.90 x 10^{-3}; **Supplementary Fig. 4E**). *TERT* and *TERC* abundances were not correlated (ρ = 0.02; P = 0.794). These data suggest that TERT signaling is not significantly abrogated in localized prostate cancer either by somatic aberrations or through gene expression changes.

To explore the relationship of *TERT* RNA abundance and tumour TL further, we considered known activating transcription factors. Transcription of *TERT* can be activated by *MYC* and *SP1* and repressed by *AR*[30]. *MYC* amplifications occur in 14.5% of our samples (51/351; **Fig. 1D**), while *SP1* CNAs are rare (3/351). *TERT* and *MYC* mRNA abundance was positively correlated (ρ = 0.27; P = 1.46 x 10^{-3}) but *MYC* abundance was unrelated to tumour TL (**Supplementary Fig. S5A)**. Contrastingly, there was a positive correlation between tumour TL length and *SP1* abundance (ρ = 0.23; P = 6.84 x 10^{-3}) but no significant correlation between *SP1* and *TERT* abundance (**Supplementary Fig. S5B**). We did not observe any statistically significant correlations between *AR* and *TERT* abundance, or tumour TL (**Supplementary Fig. S5C**). The direct relationship of these transcription factors on *TERT* is hard to elucidate because of the low measured abundance of *TERT*. Nonetheless, the abundance of *SP1* and *AR* appear to positively and negatively affect tumour TL, respectively.

To determine whether *TERT* was being regulated epigenetically, first investigated the correlation between its methylation status and its RNA abundance. We identified one CpG with a significant negative correlation and two with positive correlations (Spearman's correlation; P < 0.05; $|\rho|$ > 0.2; **Fig. 3F)**. Further, 31% (28/91) of *TERT* CpGs probes were significantly correlated to telomere length: 7 positively and 21 negatively (Spearman's correlation; FDR < 0.05; $|\rho|$ > 0.2; **Fig. 3F**). This strongly suggests that methylation of *TERT* may impact *TERT* abundance and tumour TL.

Candidate regulators of prostate tumour telomere length

Evidence of correlation between methylation and tumour TL in *TERT* led us to investigate the role of methylation on TL genome-wide. For each gene, we considered

the CpG most associated to its mRNA abundance (see **Methods**) and related that to tumour TL (n = 241). Methylation of almost half of all genes (46%; 7,088/15,492) was significantly correlated with tumour TL (Spearman's correlation; FDR < 0.05; **Supplementary Table S3)**. Similarly, almost a third of genes showed transcriptional profiles associated with tumour TL (32%; 4,500/13,958) and 9.3% showed proteomic correlations (n = 548/5,881; Spearman's correlation; P < 0.05). There were 112 genes with methylation, transcription and proteome correlations to telomere length. Remarkably, these showed no functional enrichment. Several genes showed methylation positively correlated with tumour TL but negatively correlated with RNA and protein abundance (**Fig. 4A**), suggesting suppression of tumour TL elongation. One such gene is the oncogene *AKT1*, which regulates processes including cell proliferation, survival and growth[31]. High *AKT1* abundance may indicate an elevated proliferation and therefore shorter telomeres.

We also identified genes whose methylation was negatively correlated with tumour TL but positively correlated with RNA and protein abundance suggesting promotion of telomere elongation (**Fig. 4B**). These included *SLC14A1*, a membrane transporter that mediates urea transport, and *ITGA3*, an integrin that functions as a cell surface adhesion molecule. We used g:Profiler[32] to identify 12 pathways enriched in genes that showed an association with tumour TL (n = 2,768) by methylation and RNA, including proliferation and immune processes (**Supplementary Fig. S6)**.

We similarly investigated whether TL ratio was associated with methylation and found that the methylation levels of 33.7% (5,218/15,492) of genes were significantly correlated with TL ratio (Spearman's correlation; FDR < 0.05; **Supplementary Table S4)**. Surprisingly, fewer than 1% (n = 53/13,958) of genes with overlapping data also had a significant correlation between RNA abundance and TL ratio and none between protein abundance and TL ratio (Spearman's correlation; FDR < 0.05). These results suggest that tumour TL, not TL ratio, is associated with tumour gene expression.

Association of telomere length and specific copy number aberrations

Since prostate tumour gene-expression and clinical behaviour is predominantly driven by CNAs[13,18] we next investigated their role in TL. As noted above (**Fig. 1D**), driver CNAs were largely unassociated with tumour TL (**Fig. 5A;** white background) or TL ratio (**Fig. 5B**; white background). We therefore considered copy number changes genome-wide for associations with TL. We identified 24 loci encompassing 35 genes in which there was a significant difference in tumour TL in samples with a copy number change compared to those without (Mann-Whitney U test; FDR < 0.05; **Supplementary Table S5** and **Fig. 5A**). We also identified 128 loci encompassing 319 genes in which there was an association between copy number status and TL ratio (Mann-Whitney U test, FDR < 0.05; **Supplementary Table S7**). For example, tumours with deletions in DNA methyltransferase 1, *DNMT1*, had smaller TL ratios (Q = 0.028, effect size = 0.11, **Fig.**

5B). An opposing trend was seen in the chromatin organization gene, *PRDM16* (Q = 0.027, effect size = 0.15) and the membrane metallo-endopeptidase gene, *MMEL1* (Q = 0.027, effect size = 0.14; **Fig. 5B**), where amplifications resulted in smaller TL ratios. This analysis highlights that copy number aberrations are more associated with TL ratio (change in length from non-tumour (blood) TL to tumour TL) than absolute tumour TL.

We also explored CNAs in genes comprising the telomere complex (*TERF1*, *TERF2*, *TERF2IP*, and *POT1*), shelterin interacting proteins (*PINX1* and *RTEL1),* and the components of telomerase (*TERT* and *TERC*). There were no differences in the tumour TL (**Supplementary Fig. S7A**) or TL ratio (**Supplementary Fig. S7B**) between samples with and without a CNA in these genes.

Next, we compared TL across previously identified CNA subtypes. There was no difference in tumour TL (P = 0.530; one-way ANOVA) or TL ratio (P = 0.778; one-way ANOVA) in the four CNA subtypes identified from aCGH arrays and associated with prognosis[9] (**Supplementary Fig. 8A-B**). There was an association between TL ratio and the six CNA subtypes (P = 2.12 x 10^{-2}; one-way ANOVA) identified from 284 OncoScan SNP arrays[13] but not with tumour TL (**Supplementary Fig. 8C-D**). Samples in subtype C5, which was defined by amplifications in genes near the end of chromosomes had smaller TL ratios than C3 (defined by an 8p deletion and an 8q amplification) and C4 (defined as having a quiet CNA profile). A smaller TL ratio in the samples from subtype C5 indicates that the non-tumour (blood) TL length was longer than in the tumour TL (**Supplementary Fig. 8E**): the consequences of this remain to be elucidated.

Clinical correlates of telomere length

The clinical features of a tumour can have prognostic value, and have been associated with the genomic features of tumours[13]. Higher serum abundance of prostate specific antigen (PSA), higher ISUP Grading and tumour size and extent are all associated with worse outcome. Therefore, we considered whether there was interplay between TL and the clinical features of a tumour. Tumour TL was not significantly correlated to age, (ρ = -0.10, P = 5.8 x 10^{-2}; **Fig. 6A**) but there was a significant positive correlation between age at diagnosis and TL ratio (ρ = 0.11, P = 2.53 x 10^{-2}; **Fig. 6B**). Tumour TL was shorter than non-tumour (blood) TL in younger patients. This could be related to the aggressiveness of early onset prostate cancers, which is characteristic of tumours in younger men[33]. There was a negative correlation between pre-treatment PSA levels between both tumour TL (ρ = -0.16, P = 2.23 x 10^{-3}) and TL ratio (ρ = -0.19, P = 1.70 x 10^{-4}; **Figs. 6C-D**). Neither tumour TL nor TL ratio was associated with ISUP Grade (**Figs. 6E-F**). Surprisingly, tumour TL was shorter in smaller tumours (T1) than larger tumours (T2 or T3; one-way ANOVA, P = 2.2 x 10^{-2}; **Fig. 6G**) but this can be explained by the higher average age of patients with T1 tumours (mean = 71.3) compared to other

T categories (mean = 62.0). Accordingly, there was no association between TL ratio, which controls for patient age, and T category (P = 0.29; **Fig. 6H**).

Telomerase activity and TL has been proposed to have clinical utility at three different stages; diagnosis, prognosis and treatment[30]. TL from biopsies has been correlated with progression to metastasis and disease specific death[34]. As well, TL from leukocytes has been associated with poor survival[35,36]. We explored if tumour TL, non-tumour (blood) TL or TL ratio were associated with biochemical relapse (BCR), an early surrogate endpoint in intermediate-risk prostate cancer. Cox proportional hazards (Cox PH) models were fit, splitting patients (n = 290) into two groups based on their TL with increasing cutoff thresholds (50 bp each time; **Supplementary Fig. S9**). From this outcome-oriented optimal cut-point analysis we discovered that samples with non-tumour (blood) TL less than 3.9 kbp had a higher rate of BCR than samples with longer TLs (HR = 2.02, P = 1.6 x 10^{-3}; **Fig. 6I**). Non-tumour (blood) TL is associated with survival independent of PGA (Cox PH model, P = 0.02). There was no association between tumour TL and BCR (**Fig. 6J**), but there was an association between TL ratio and BCR , where samples with a TL ratio greater than 0.65 had a lower rate of BCR (HR = 0.42, P = 2.6 x 10^{-3}; **Fig. 6K**). We also considered TL as a continuous measurement and fit Cox PH models using tumour TL, non-tumour (blood) TL and TL ratio. Again, there was no association between continuous tumour TL and BCR but there was an association between non-tumour (blood) TL (HR = 0.768, P = 0.014) and TL ratio (HR = 1.71, P = 0.031; **Supplementary Fig. 9D**). These results suggest that non-tumour (blood) TL and TL ratio are weakly prognostic, and thus may reflect host factors that may influence patient risk categorization.

Discussion

These data emphasize the relationship of genomic instability and TL. Genomic instability has previously been linked with poor outcome in prostate cancer[9,13] and TL shortening could be the cause of some of this instability. Telomere shortening has been implicated as an early event in prostate cancer due to evidence of shortened telomeres observed in a precursor histopathology, high-grade prostatic intraepithelial neoplasia[37,38]. Since cellular proliferation in prostate cancer is increased by seven fold compared to normal prostatic epithelial cells[30], telomeres in these dividing cells will shorten with each cell division. There is no evidence that primary prostate cancer exhibits ALT lengthening[22] therefore the vast majority, if not all tumours, activate telomerase for telomere maintenance. We did not observe any *TERT* promoter mutations in our cohort but there are strong negative correlations between methylation probes in the promoter of *TERT* and tumour TL. This may be a proxy for telomerase activity since DNA methylation impedes transcription.

We see an unexpected divergence between somatic molecular features associated with TL ratio and those with tumour TL. Specifically, measures of genomic instability are linked to TL ratio (which represents the ratio between blood TL and tumour TL) while specific CNAs, GRs, and SNVs are not (**Fig. 1** and **Supplementary Fig. 2**). This suggests that during the progression of cells from normal to cancerous, non-tumour (blood) TL may influence tumour genomics, where tumours with shorter TL experience more genomic instability. Alternatively, a common factor may be influencing during this epoch of the tumour's evolution. Once tumours are formed, it is the specific mutations within the cell that are more associated with tumour TL. This may be due to mutations in cell division and growth regulating genes such as *ATK1* and *SPOP*, which increases the number of divisions in the tumour and thereby shortens tumour telomeres. Further evidence of this hypothesis is seen in tumours with *PCAT1* fusions, where tumours with this fusion had shorter tumour TL than samples without it[39].

One limitation in the estimation of TL using short-read whole genome sequencing is the difficulty in estimating chromosome specific telomere lengths. Junction spanning reads from paired-end experiments, in which one read maps within the first or last band of the chromosome and the other read maps within the telomere region, are scarce. Further studies should be performed using long read sequences, in which these regions may have more coverage and can be used to determine chromosome specific shortening and its association to specific genomic events or biochemical relapse.

These data highlight the complicated relationship between telomere length in both tumour and non-tumour cells, and molecular and clinical tumour phenotypes. They highlight the need for increased study of telomere length across cancer types, and for long-read sequencing to introduce chromosome-specific analyses.

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Author contributions

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Declaration of Interest and Financial Disclosures

All authors declare that they have no conflicts of interest.

Figure Legends

Figure 1. Tumour telomere length (TL) is associated with genomic features. A, Correlation between tumour TL and non-tumour (blood) TL. **B,** Correlation between tumour TL and TL ratio (tumour TL / non-tumour (blood) TL). **C,** Correlation between non-tumour (blood) TL and TL ratio. **D,** Tumour TL is ranked in descending order of length (kbp; top bar plot). The association of tumour TL and measures of mutational burden, TMPRSS2:ERG (T2E) fusion status, as well as known prostate cancer genes with recurrent CNAs, coding SNVs, and GRs are shown. Bar plots to the right indicate the statistical significance of each association (see **Methods)**.

Figure 2. Mutational landscape differs with telomere length. A-B, Correlation between the number of SNVs and **A,** tumour TL and **B,** TL ratio. **C-D,** Correlation between the number of indels and **C,** tumour TL and **D,** TL ratio. **E-F,** Correlation between the number of GRs and **E,** and tumour TL and **F,** TL ratio. **G-H,** Correlation of percentage of the genome altered (PGA) and **G,** tumour TL and **H,** TL ratio. **I-J,** Correlation between the number of fusions and **I,** tumour TL and **J,** TL ratio. Orange dots indicate tumour TL while green dots indicate TL ratio. Spearman ρ and p-values are displayed.

Figure 3. The genomic correlates of *TERT* abundance. A, Correlation of *TERT* RNA abundance with tumour TL and TL ratio. Orange dots indicate tumour TL while green dots indicate TL ratio. Spearman ρ and p-values are displayed. **B-E,** Correlation of *TERT* abundance and **B,** the number of GRs, **C,** number of SNVs, **D,** number of indels, and **E,** PGA. Spearman ρ and p-values are displayed. **F**, Spearman's correlation of significantly associated methylation probes with RNA abundance and tumour TL. Blue dots indicate a positive correlation while orange dots indicate a negative correlation. Probes within the promoter are labeled in red while the rest are located in the gene body. Dot size indicated the magnitude of correlation. Background colour indicates unadjusted p-values. Methylation probes are ordered by their correlation between *TERT* RNA abundance from negative to positive.

Figure 4. Association of methylation, RNA abundance, protein abundance and telomere length. A, Positive correlation of methylation and tumour TL, but negative correlation of RNA and protein abundance. Top panels in light blue represent methylation, middle panels in blue-grey represent RNA abundance and the bottom panels in purple represent protein abundance. Darker purple dots represent undetected, imputed abundance measures. Spearman ρ and p-values are displayed. **B,** Negative correlation of methylation and tumour TL, but positive correlation of RNA and protein abundance. Top panels in light blue represent methylation, middle panels in blue-grey represent RNA abundance and the bottom panels in purple represent protein abundance. Darker purple dots represent undetected, imputed protein abundance measures. Spearman ρ and p-values are displayed.

Figure 5. Telomere length differs by copy number status. A, Difference in tumour TL between samples with a copy number aberration and those without in prostate cancer related genes and associated genes. **B,** Difference in TL ratio between samples with a copy number aberration and those without in prostate cancer related and associated genes. Q-values are from a Mann-Whitney U test and are bolded when significant (FDR < 0.05). Colour of the points indicate copy-number status of the gene: amplification (red), deletion (blue), or neutral (black).

Figure 6. Telomere length is associated with clinical features and biochemical relapse. A-B, Correlation of age at diagnosis with **A,** tumour TL and **B,** TL ratio. Spearman ρ and p-values are displayed. **C-D,** Correlation of pre-treatment PSA with **C,** tumour TL and **D,** TL ratio. Spearman ρ and p-values are displayed. **E-F,** Association of ISUP grade with **E,** tumour TL and **F,** TL ratio. P-value is from an one-way ANOVA. **G-H,** Association of T category with **G,** tumour TL and **H,** TL ratio. P-value is from an one-way ANOVA. On all plots, green indicates TL ratio, while orange indicates tumour TL. **I-K,** Cox proportional hazard models were created for **I,** non-tumour (blood) TL**, J,** tumour TL and **K,** TL ratio with BCR as the endpoint. Samples were split into two groups based on the optimal cut point analysis (**see Methods**).

Methods

CPC-GENE patient cohort

Patient selection, tissue collection and sample processing has been previously described in detail[13]. Briefly, informed consent, consistent with the guidelines of the local Research Ethics Board (REB) and International Cancer Genome Consortium (ICGC), was obtained at the time of clinical follow-up. Previously collected tumour tissues were used, following University Health Network REB-approved study protocols (UHN 06-0822-CE, UHN 11-0024-CE, CHUQ 2012-913:H12-03-192). All patients were male and N0M0 as an entry criterion for the study. For RadP patients, BCR was defined as two consecutive post-RadP PSA measurements of more than 0.2 ng/ml (backdated to the date of the first increase). If a patient has successful salvage radiation therapy, this is not BCR. If PSA continues to rise after radiation therapy, BCR is backdated to first PSA > 0.2. If patient gets other salvage treatment (such as hormones or chemotherapy), this is considered BCR. Tumour cellularity and Gleason grades were evaluated independently by two genitourinary pathologists on scanned haematoxylin- and eosin-stained slides. Serum PSA concentrations (ng/mL) are reported according to the reading at the time of diagnosis. Cellularity was also determined *in silico* from OncoScan SNP arrays via qpure (v1.1)[40].

Whole-genome sequencing and data analysis

Whole-genome sequencing was conducted as described before[13]. Briefly, sequencing libraries were prepared using 50 ng of gDNA and enzymatic reagents from KAPA Library Preparation Kits (KAPA Biosystems, Woburn, MA USA Cat#KK8201) according to protocols as described for end repair, A-tailing, and adapter ligation[41]. Sequencing was carried out on the Illumina HiSeq 2000 platform (Illumina Inc.) and samples were sequenced to a minimum coverage depth of 50x and 30x for tumour and non-tumour (blood) samples, respectively.

Raw sequencing reads were aligned to the human reference genome, GRCh37, using BWA-mem (version > 0.7.12; [42] at the lane level. Picard (v1.92; http://broadinstitute.github.io/picard/) was used to merge the lane-level BAMs from the same library and mark duplicates. Library level BAMs from each sample were also merged without marking duplicates using Picard. Local realignment and base quality recalibration was carried out on tumour/non-tumour (blood) pairs together using the Genome Analysis Toolkit (GATK; > version 3.4.0; [43]. Tumour and non-tumour (blood) sample level BAMs were extracted, headers were corrected using SAMtools (v0.1.9; [44], and files were indexed with Picard (v1.92).

Computational telomere length estimation

Tumour and non-tumour (blood) telomere length was estimated using TelSeq (v0.0.1; [23] and TelomereHunter (v1.0.4)[24] on BAM files generated using bwa-mem (version >

0.712; [42] and GATK (version > 3.4.0; [43]. As a quality measure, TelSeq estimates for each sample were generated per sequencing lane. Reads from lanes that contained too few reads to calculate an estimate (marked as UNKNOWN), and outlier lanes as identified by grub's test, were removed from input BAMs using BAMQL v1.6)[45]. After outliers were removed, TelSeq was run again ignoring read groups with the -u parameter. Samples with telomere estimates less than one were removed from further analysis. To account for differences in TL due to sequencing center, a linear model was fit with TL as the response variable and sequencing center as the predictor variable. A separate model was fit for tumour and non-tumour (blood) length.

Somatic variant calling

Single nucleotide variants (SNVs) and genomic rearrangements (GRs) were called using pipelines that have been described in detail elsewhere[13]. Briefly, SomaticSniper (v1.0.5; [46] was used to call SNVs on bases with at least 17x coverage in tumours and 10x in non-tumours (blood). Coding versus non-coding SNVs were determined using Annovar[47]. Genomic rearrangements were identified using Delly (version 0.7.8; [48]. Gene fusion events involving *ERG* or *ETV* were collectively referred to as ETS events. Genomic rearrangement calls were examined to determine if breakpoints led to a TMPRSS2:ERG fusion or if breakpoints were found in both 1 Mbp bins surrounding the following gene pairs: *ERG*:*SLC45A3*, *ERG*:*NDRG1*, *ETV1*:*TMPRSS2*, *ETV4*:*TMPRSS2*, *ETV1*:*SLC45A3*, *ETV4*:*SLC45A3*, *ETV1*:*NDRG1*, and *ETV4*:*NDRG1*. *ERG* immunohistochemistry and deletion calls between *TMPRSS2* and *ERG* loci in OncoScan SNP array data provided further support for these fusions.

mRNA abundance data generation and analysis

Generation and analysis of mRNA abundance data has been previously described in detail[13]. Briefly, total RNA was extracted using the mirVana miRNA Isolation Kit (Life Technologies), according to the manufacturer's instructions. 100-150 ng of total RNA was assayed on the Human Gene 2.0 ST array or the Affymetrix Human Transcriptome Array 2.0. Background correction, normalization and annotation were carried out using the oligo (v1.34.2) package. The robust multichip average (RMA) algorithm was applied to the raw intensity data[49]. Probes were mapped to Entrez gene IDs using custom CDF files (v20) for HTA 2.0 and HuGene 2.0 ST array.

Methylation microarray data generation

Illumina Infinium HumanMethylation 450k BeadChip kits were used to assess global methylation, using 500 ng of input genomic DNA, at McGill University and the Genome Quebec Innovation Centre (Montreal, QC). All samples used in this study were processed from fresh-frozen prostate cancer tissue. The IDAT files were loaded and converted to raw intensity values with the use of wateRmelon package (v1.15.1; [50]. Quality control was conducted using the minfi package (v1.22.1; [51]; no outlier samples were detected). Raw methylation intensity levels were then pre-processed using Dasen.

Probe filtering was conducted after normalization, as previously described[13]. Annotation to chromosome location, probe position, and gene symbol was conducted using the IlluminaHumanMethylation450kanno.ilmn12.hg19 package (v0.6.0).

Association of telomere length with chromothripsis

Chromothripsis scores were previously generated using ShatterProof (v0.14; [13,25] with default settings. Spearman's correlation between the maximum ShatterProof score per sample and telomere length was calculated using samples with both available metrics (n = 170).

Association of telomere length with clinical and genomic features

Telomere length estimates were associated with genomic and clinical features. Clinical features, including ISUP Grade, pre-treatment PSA, T category and age at diagnosis, were categorized and tested for association using an one-way ANOVA. Pathological T category was used for surgery samples and diagnostic T category was used for radiotherapy samples. Binary features including the presence of specific GRs, CNAs and SNVs were tested for association using a Mann-Whitney U test. Summary features including PGA, GR count, SNV count and indel count were correlated to TL using Spearman's correlation.

Association of telomere length with methylation

The correlation matrix of methylation and mRNA abundance levels from TCGA was downloaded from https://gdac.broadinstitute.org/. For each gene, the probe showing the highest Spearman's correlation with mRNA abundance levels was used in our correlation analysis.

Association of telomere length with transcriptome abundance

Spearman's correlations between RNA abundance (n = 139; [13] and TL, as well as, protein abundance (n = 70; [16] and TL were calculated. Pathway analysis was performed with g:ProfileR[32] using genes that were significantly negatively or positively correlated to TL.

Association of telomere length with copy number aberrations

Microarray data generation and analysis has been previously described in detail[13]. Briefly, SNP microarrays were performed with 200 ng of DNA on Affymetrix OncoScan FFPE Express 2.0 and 3.0 arrays. Analysis of the probe assays was performed using .OSCHP files generated by OncoScan Console (v1.1) using a custom reference. BioDiscovery's Nexus Express™ for OncoScan 3 Software was used to call copy number aberrations using the SNP-FASST2 algorithm. Gene level copy number aberrations for each patient were identified by overlapping copy number segments from OncoScan SNP 3.0 data, with RefGene (2014-07-15) annotation using BEDTools (v2.17.0; [52]. Genes with the same copy number profile across patients were then collapsed into contiguous regions. Contiguous gene segments with aberrations in less

that 5% of patients were removed from the analysis. To find associations between TL and copy number segments, a Mann-Whitney U test was used to compare the mean TL between samples with a copy number aberration and those without. P-values were FDR adjusted to account for multiple testing.

Association with biochemical relapse

Cox proportional hazards models were fit with the R package survival (v3.2-7) using TL as a continuous variable. Age at diagnosis was controlled for in the model. Kaplan Meier plots were generated by dichotomizing samples based on the optimal cut point analysis, in which samples were dichotomized using increasing thresholds of 50 bp.

Statistical analyses and data visualization

All statistical analyses were performed within the R statistical environment (v3.3.1). Visualization in R was performed through the BoutrosLab Plotting General package (v5.6.1; [53].

Data availability

OncoScan SNP array data and whole genome DNA sequencing can be found on EGA under the accession EGAS00001000900. Processed variant calls are available through the ICGC Data Portal under the project PRAD-CA (https://dcc.icgc.org/projects/PRAD-CA). mRNA data is available in the Gene Expression Omnibus under the accession GSE84043. Methylation data is available under the accession GSE107298.

Supplementary Table Legends

Supplementary Table 1 | Clinical and Genomic Features of Tumours

Clinical data for 382 samples used in analysis after applying quality control metrics.

Supplementary Table 2 | Association between Tumour TL and recurrent gene fusions

Statistical summary of 47 recurrent fusions pairs tested for association with TL using a Wilcoxon signed-rank test.

Supplementary Table 3 | Genomic and transcriptomic correlations with Tumour TL

Results from Spearman's correlation between tumour TL and methylation beta values, RNA abundance and protein abundance. Q-values are FDR adjusted P-values. NAs indicate missing values where tests could not be performed.

Supplementary Table 4 | Genomic and transcriptomic correlations with TL ratio

Results from Spearman's correlation between tumour TL and methylation beta values, RNA abundance and protein abundance. Q-values are FDR adjusted P-values. NAs indicate missing values where tests could not be performed.

Supplementary Table 5 | Associations between CNAs and Tumour TL

Associations between CNAs and Tumour TL, ordered by FDR adjusted P-values. Each row represents collapsed segments containing multiple genes. Contiguous gene segments with aberrations in less that 5% of patients were removed.

Supplementary Table 6 | Associations between CNAs and TL ratio

Statistically significant associations between CNAs and TL ratio, ordered by FDR adjusted P-values. Each row represents collapsed segments containing multiple genes. Contiguous gene segments with aberrations in less that 5% of patients were removed.

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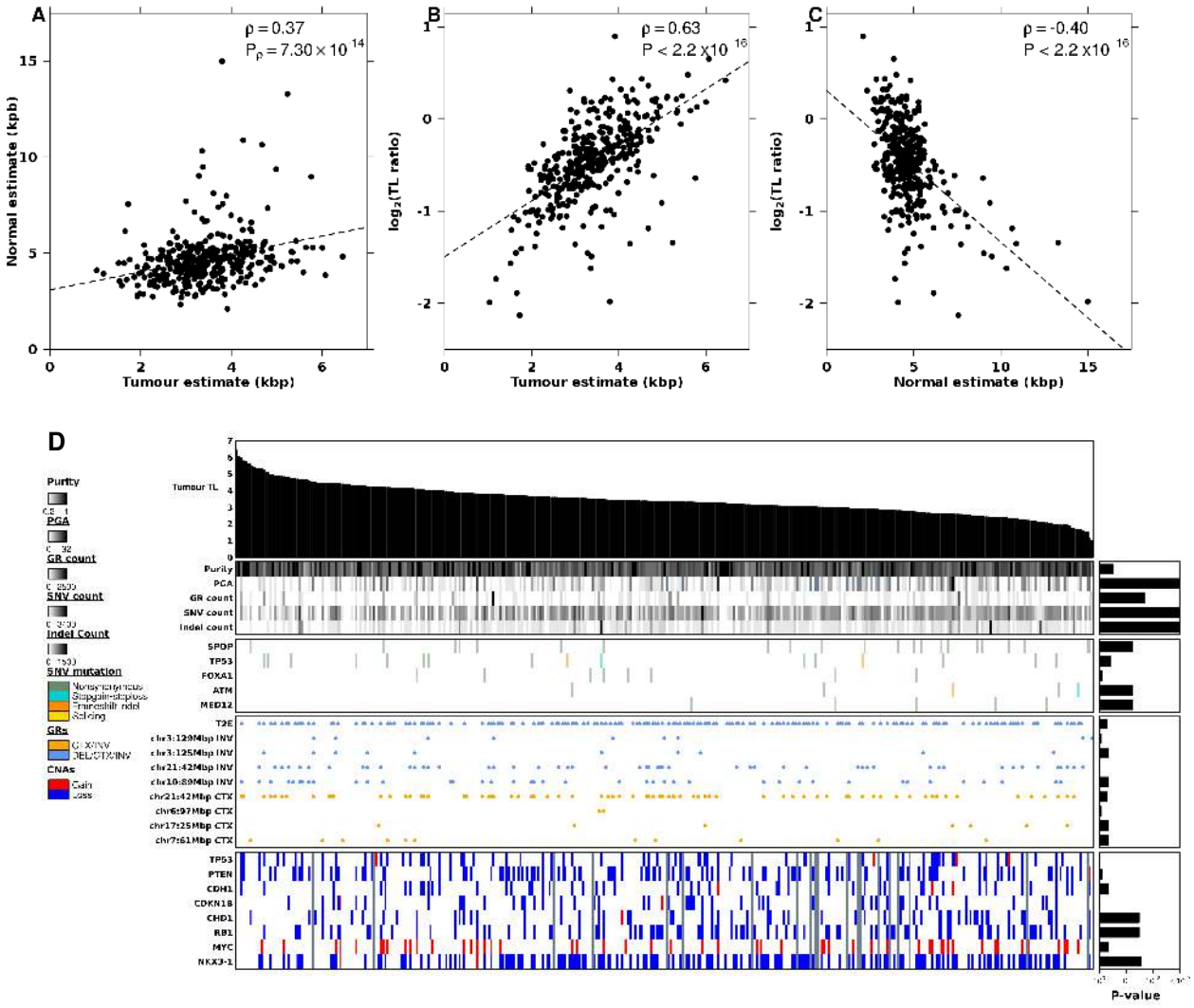

Figure 1 — Tumour telomere length (TL) is associated with genomic features
A-B, Correlation between tumour TL and **A** non-tumour (blood) TL and **B**, TL ratio (tumour TL / non-tumour (blood) TL). **C**, Correlation between non-tumour (blood) TL and TL ratio. **D**, Tumour TL is ranked in descending order of length (kbp; top bar plot). The association of tumour TL and measures of mutational burden, TMPRSS2:ERG (T2E) fusion status, as well as known prostate cancer genes with recurrent CNAs, coding SNVs, and GRs are shown. Bar plots to the right indicate the statistical significance of each association **(see Methods)**.

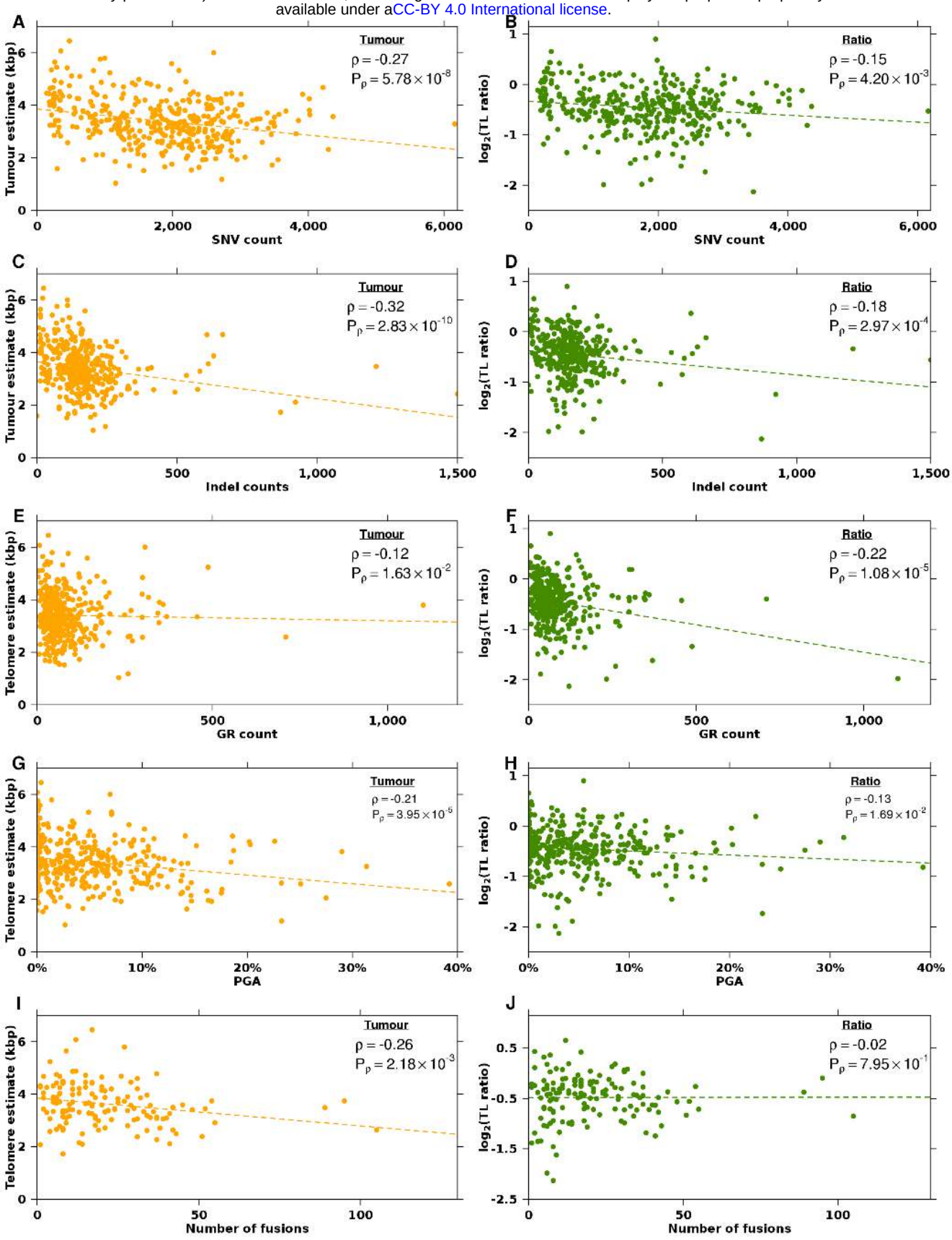

Figure 2 — Mutational landscape differs with telomere length

A-B, Correlation between the number of SNVs and **A**, tumour TL and **B**, TL ratio. **C-D**, Correlation between the number of indels and **C**, tumour TL and **D**, TL ratio. **E-F**, Correlation between the number of GRs and **E**, and tumour TL and **F**, TL ratio. **G-H**, Correlation of percentage of the genome altered (PGA) and **G**, tumour TL and **H**, TL ratio. **I-J**, Correlation between the number of fusions and **I**, tumour TL and **J**, TL ratio. Orange dots indicate tumour TL while green dots indicate TL ratio. Spearman's ρ and P-values are displayed.

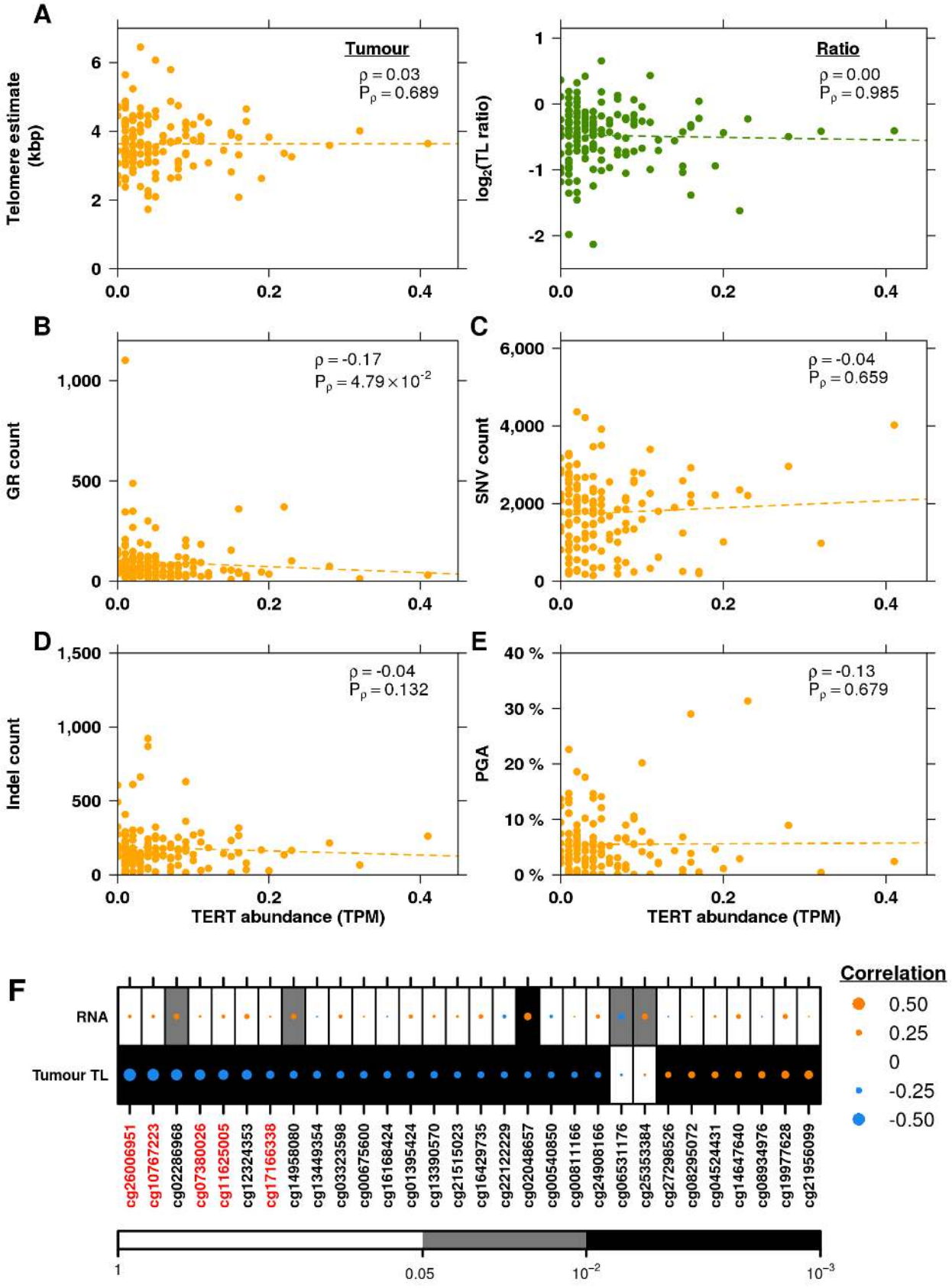

Figure 3 — The genomic correlates of TERT abundance

A, Correlation of *TERT* RNA abundance with tumour TL and TL ratio. Orange dots indicate tumour TL while green dots indicate TL ratio. Spearman ρ and P-values are displayed. **B-E**, Correlation of *TERT* abundance and **B**, the number of GRs, **C**, number of SNVs, **D**, number of indels, and **E**, PGA. Spearman ρ and P-values are displayed. **F**, Spearman's correlation of significantly associated methylation probes with RNA abundance and tumour TL. Orange dots indicate a positive correlation while blue dots indicate a negative correlation. Probes within the promoter are labeled in red while the rest are located in the gene body. Dot size indicated the magnitude of correlation. Background colour indicates unadjusted P-values. Methylation probes are ordered by their correlation between *TERT* RNA abundance from negative to positive.

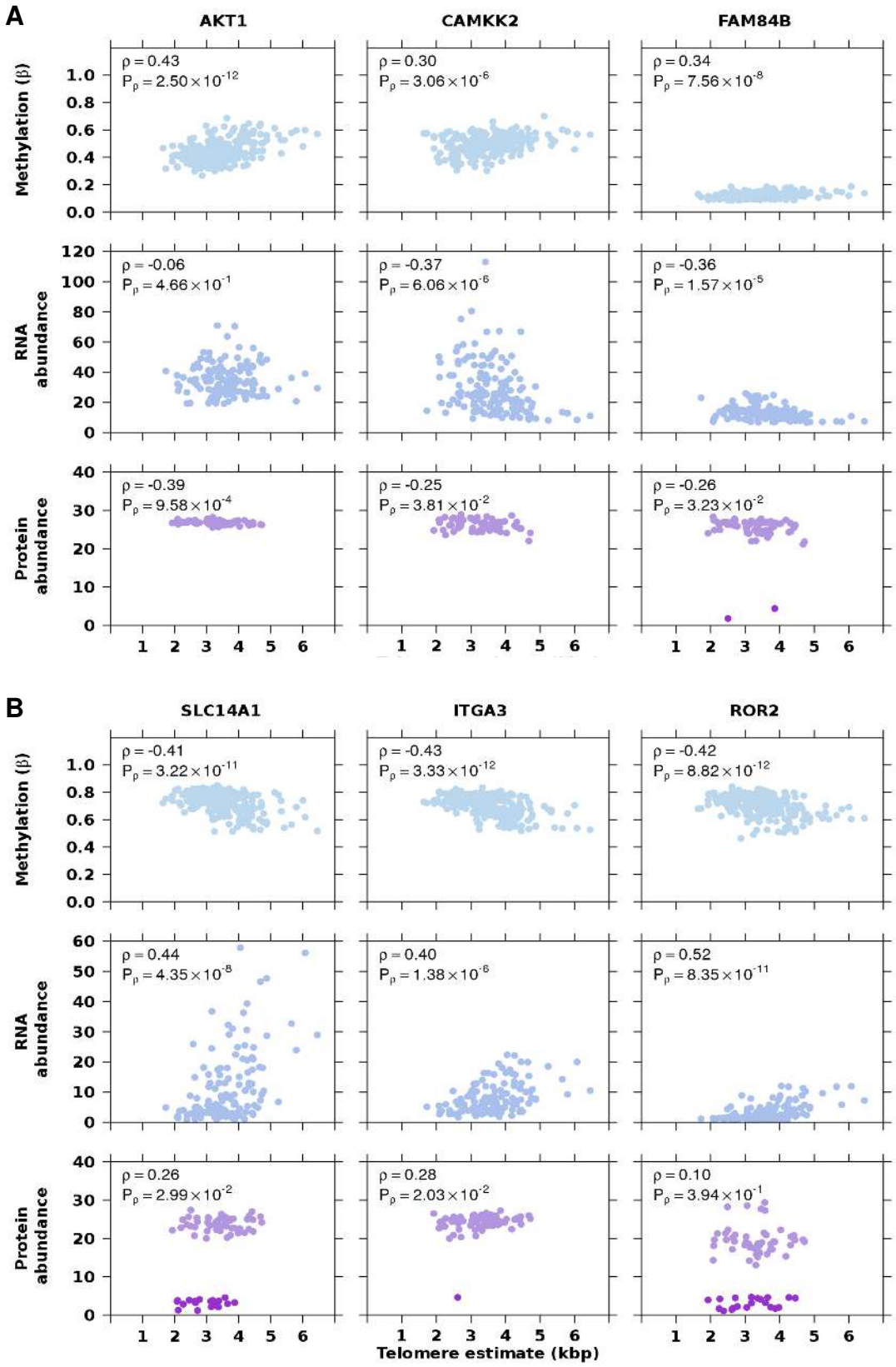

Figure 4 — Association of methylation, RNA abundance, protein abundance and telomere length
A, Positive correlation of methylation and tumour TL, but negative correlation of RNA and protein abundance. **B**, Negative correlation of methylation and tumour TL, but positive correlation of RNA and protein abundance. Top panels in light blue represent methylation beta values, middle panels in blue-grey represent RNA abundance and the bottom panels in purple represent protein abundance. Darker purple dots represent undetected, imputed protein abundance measures. Spearman ρ and P-values are displayed.

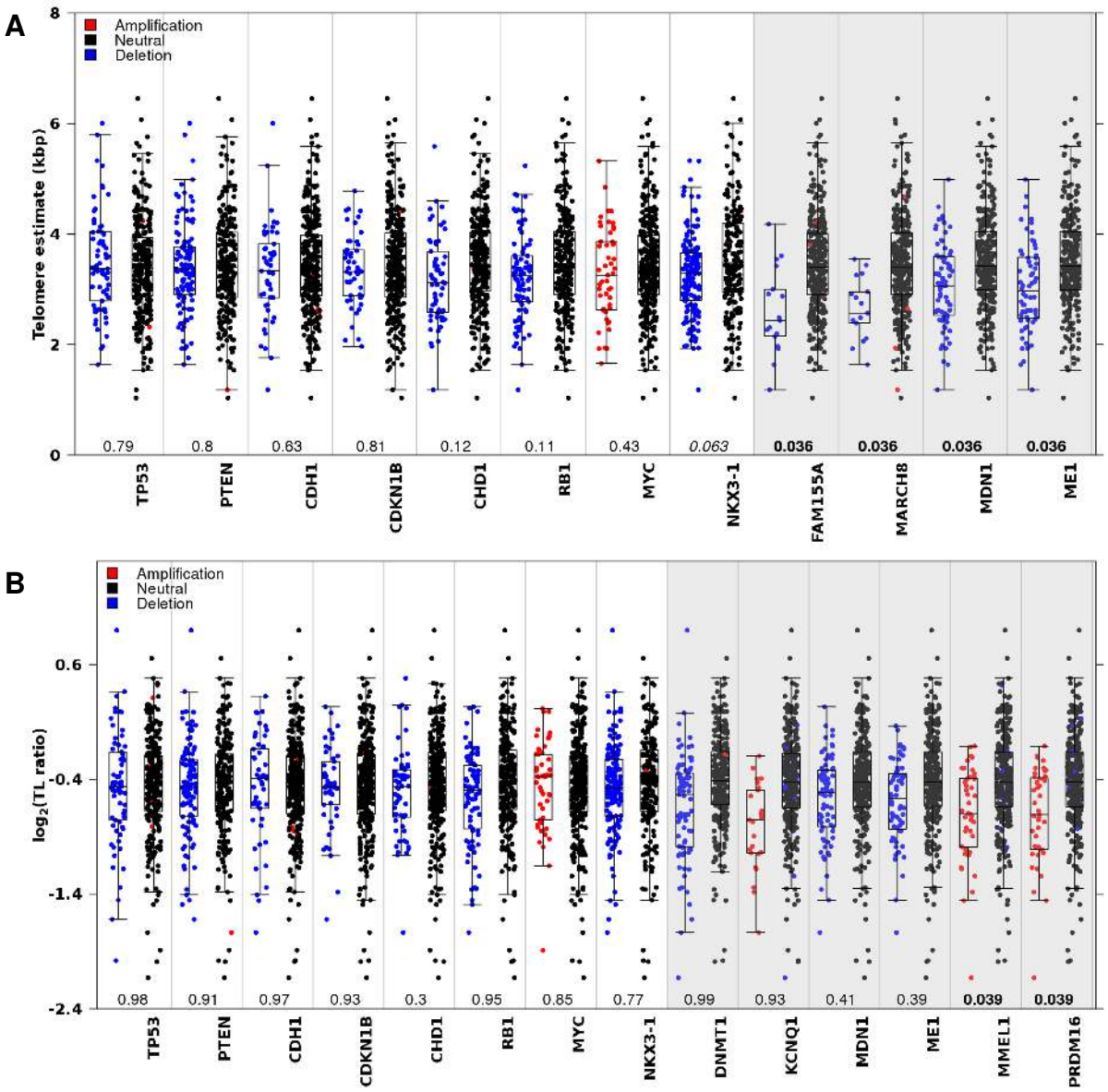

Figure 5 — Telomere length differs by copy number status

A, Difference in tumour TL between samples with a copy number aberration and those without in prostate cancer related genes and associated genes. **B**, Difference in TL ratio between samples with a copy number aberration and those without in prostate cancer related and associated genes. Q-values are from a Mann-Whitney U test and are bolded when significant (< 0.05). Colour of the dots indicate copy number status of the gene: amplification (red), deletion (blue), or neutral (black). Boxes with a white background are known prostate cancer genes, while boxes with a gray background were identified by a genome wide search.

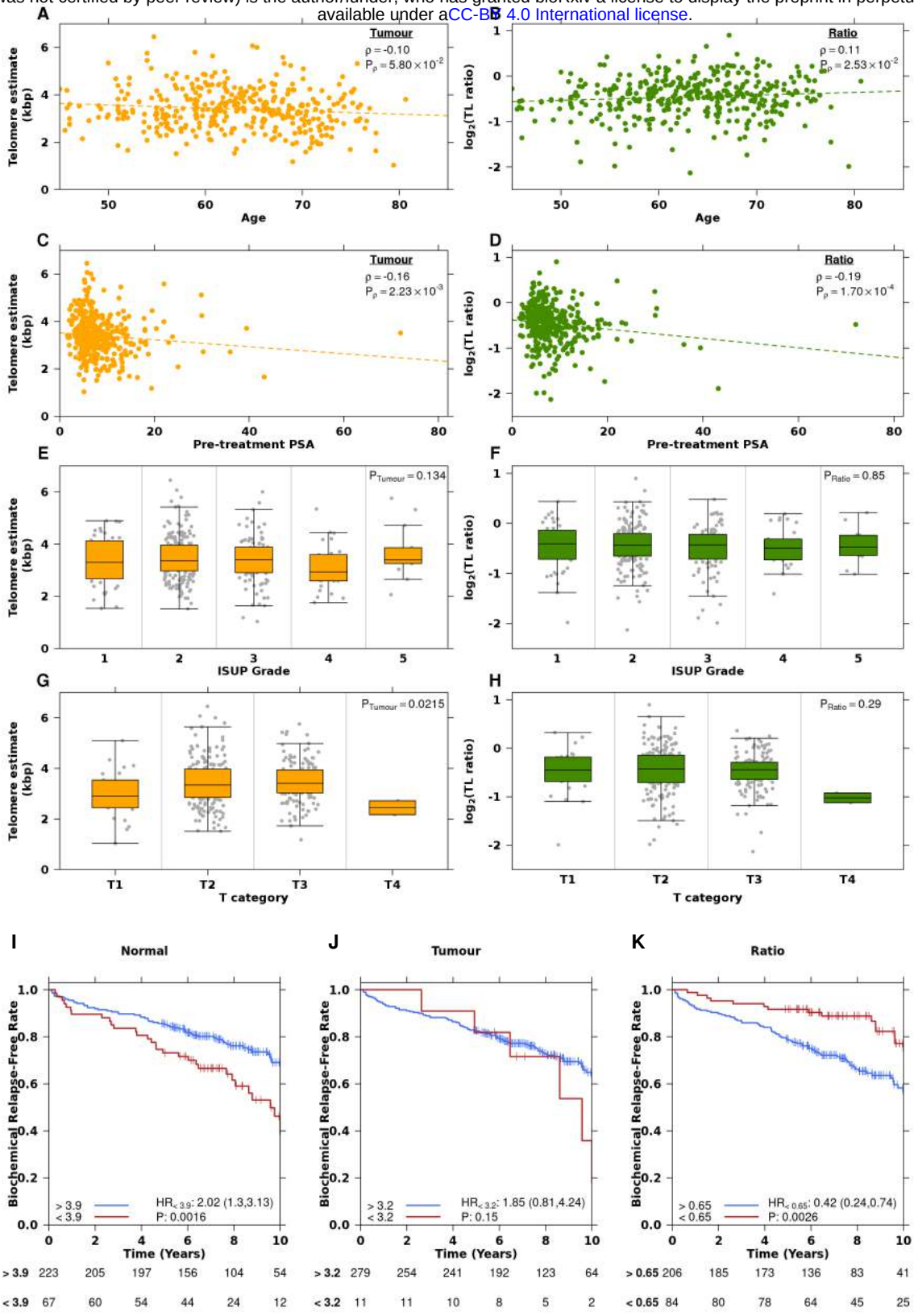

Figure 6 — Telomere length is associated with clinical features and biochemical relapse

A-B, Correlation of age at treatment with **A**, tumour TL and **B**, TL ratio. Spearman ρ and P-values are displayed. **C-D**, Correlation of pre-treatment PSA with **C**, tumour TL and **D**, TL ratio. Spearman ρ and P-values are displayed. **E-F**, Association of ISUP grade with **E**, tumour TL and **F**, TL ratio. P-value is from an one-way ANOVA. **G-H**, Association of T category with **G**, tumour TL and **H**, TL ratio. P-value is from an one-way ANOVA. On all plots, green indicates TL ratio, while orange indicates tumour TL. **I-K**, Cox proportional hazard models were created for **I**, non-tumour (blood) TL, **J**, tumour TL and **K**, TL ratio with BCR as the endpoint. Samples were split into two groups based on the optimal cut point analysis **(see Methods)**.