African-specific prostate cancer molecular taxonomy

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African-specific prostate cancer molecular taxonomy

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Abstract

Prostate cancer is characterised by significant global disparity; mortality rates in Sub-Saharan Africa are double to quadruple those in Eurasia\(^1\). Hypothesising unknown interplay between genetic and non-genetic factors, tumour genome profiling envisages contributing mutational processes\(^2,3\)\. Through whole-genome sequencing of treatment-naïve prostate cancer from 183 ethnically/globally distinct patients (African versus European), we generate the largest cancer genomics resource for Sub-Saharan Africa. Identifying ~2 million somatic variants, Africans carried the greatest burden. We describe a new molecular taxonomy using all mutational types and ethno-geographic identifiers, including Asian. Defined as Global Mutational Subtypes (GMS) A–D, although Africans presented within all subtypes, we found GMS-B to be ‘African-specific’ and GMS-D ‘African-predominant’, including Admixed and European Africans. Conversely, Europeans from Australia, Africa and Brazil predominated within ‘mutationally-quiet’ and ethnically/globally ‘universal’ GMS-A, while European Australians shared a higher mutational burden with Africans in GMS-C. GMS predicts clinical outcomes; reconstructing cancer timelines suggests four evolutionary trajectories with different mutation rates (GMS-A, low 0.968/year versus D, highest 1.315/year). Our data suggest both common genetic factors across extant populations and regional environmental factors contributing to carcinogenesis, analogous to gene-environment interaction defined here as a different effect of an environmental surrounding in persons with different ancestries or vice versa. We
anticipate GMS acting as a proxy to intrinsic and extrinsic mutational processes in cancers, promoting global inclusion in landmark studies.
Prostate cancer is a common heterogeneous disease, responsible annually for more than 1,400,000 new diagnoses and 375,000 male-associated deaths worldwide. Characterised by a highly variable natural history and diverse clinical behaviours, it is not surprising that genome profiling has revealed extensive intra- and inter-tumour heterogeneity and complexity. The identification of oncogenic subtypes and actionable drug targets are moving prostate cancer management a step closer to the promise of precision medicine. While high-income European ancestral countries are well along the road to incorporating cancer genomics in all aspects of cancer care, the rest of the world lags behind, with a notable absence in Sub-Saharan Africa. Prostate cancer is no different, with a single large-scale study out of China; in 2018, we provided the first snapshot for Sub-Saharan Africa, reporting an elevated mutational density in a mere six cases. With mortality rates over double high-income countries and quadrupled for greater Asia, Sub-Saharan Africa prostate cancer is the top-ranked male-associated cancer both by diagnosis and deaths, including southern Africa with age-standardised rates of 65.9 and 22 per 100,000, respectively. Through the Southern African Prostate Cancer Study (SAPCS), we report a 2.1-fold increase in aggressive disease compared to African Americans. Here we describe, to our knowledge, the largest cancer and prostate cancer genomics data for Sub-Saharan Africa, including 123 South African men. Controlling for study artefacts, an additional 60 non-Africans were passed simultaneously through the same high-depth whole-genome sequencing (WGS), mutation-calling and analytical framework. Focusing on treatment-naïve aggressive tumours (mostly Grades 4-5, Extended Data Fig. 1a) and patient-matched blood achieving coverages of
88.69±14.78 and 44.34±8.11, respectively (median±s.d., Supplementary Table 1), we uniformly generated, called and assessed about 2 million somatic variants. We show a greater number of acquired genetic alterations within Africans, while identifying both globally relevant and African-specific genomic subtypes. Through combining our somatic variant dataset with that published for European-ancestral7,8,18,19 and Chinese12 prostate cancer genomes, we reveal a novel prostate cancer taxonomy with different clinical outcomes. The inclusion of 2,658 cancer genomes from the ICGC/TCGA Pan-Cancer Analysis of Whole Genomes (PCAWG)14 led to expanding our global mutational subtyping between cancer types. Using known clock-like mutational processes in each subtype, we infer mutation timing of oncogenic drivers in broad periods of tumour evolution and calculate mutation rates for each subtype that had a distinctive tumour evolution pattern. Combined, these analyses allow us to demonstrate how global inclusion in cancer genomics can unravel unseen heterogeneity in prostate cancer in terms of its genomic and clinical behaviours.

Genetic ancestry

Genetic ancestries were estimated for the 183 patient donors using a joint dataset in a unified analysis aggregated from a collection of geographically matched African (n=64) and European (n=4) deep-coverage reference genomes20,21. Ancestries were assigned using 7,472,833 markers as: African (n=113), with greater than 98% contribution; European (n=61), allowing for up to 10% Asian contribution (with a single outlier of 26%); and African-European Admixed (n=9), with as little as 4% African or European contribution (Extended Data Fig. 1b).

Total somatic mutations
In 183 prostate tumours, we identified 1,067,885 single nucleotide variants (SNVs), 11,259 dinucleotides, 307,263 small insertions/deletions (indels <50 bp), 419,920 copy number alterations (CNAs) and 22,919 structural variants (SVs), with each mutational type elevated in African derived tumours (Fig. 1a). A median of 37.54%±5.51 of SNVs were C-to-T mutations, and the transition and transversion ratio was 1.282 cohort-wise. African derived tumours harboured a higher rate of small mutations (SNVs and indels), with a median of 1.197 mutations/Mb (0.031-170.445), compared to those of Europeans (1.061 mutations/Mb, $P$-value = 0.013, two-sample t-test). Percent genome alteration (PGA) was similarly greater in Africans (0.073 versus 0.028, $P$-value = 0.021). Correlation tests of ethnicity and total somatic mutations also supported the findings (FDR=0.009 and 0.032 for SNVs and PGA, respectively, Extended Data Fig. 1d). The top six highest estimates of SV breakpoints per sample were observed among African patients (928-2,284 breakpoints). Intrachromosomal SV breakpoints were 52-55% positive for chromothripsis among Africans and Europeans (median, 3 and 2 high-confidence events, respectively). Chromoplexy was more frequent in Europeans than in Africans (38% versus 33%, $P$-value=0.536), with the number of interchromosomal chains more likely to be elevated in Africans than Europeans (1-6 versus 1-2, $P$-value=0.748). Moreover, the magnitude of all types of mutations was strongly correlated to one another (Fig. 1b). Thus, the more mutations a prostate tumour has of any given type, the more mutations it is likely to have of all types.

**Candidate oncogenic drivers**

Prostate cancer is known to have a long tail of oncogenic drivers across the spectrum of different mutational types (Extended Data Fig. 2). Protein-coding
mutations, including probably and possibly damaging, were significantly greater in Africans (PolyPhen-2, 14 versus 11 mutations in Europeans, $P$-value=0.022, two-sample t-test). We identified 482 coding and 167 noncoding drivers defined by the PCAWG Consortium (Extended Data Fig. 3a). A median of 2±22.5 coding drivers was observed in this study (Supplementary Table 2), with 1±5.4 appearing to be prostate cancer-specific. The coding driver genes significantly mutated among 183 patients were FOXA1, PTEN, SPOP and TP53 (10-25 patients, FDR=1.34e-21–9.44e-05), while noncoding driver elements were the FOXA1 3’-UTR, SNORD3B-2 small RNA and a regulatory miRNA promoter at chromosome 22:38,381,983 (FDR=9.12e-13, 6.16e-09 and 0.070, respectively). Recurrent CNAs of all the patients included 137 gains and 129 losses (GISTIC2, FDR <0.10, Supplementary Table 3) with some spanning driver genes (Extended Data Fig. 3b), such as DNAH2 (FDR=2.18e-07), FAM66C (1.30e-09), FOXP1 (0.005), FXR2 (2.18e-07), PTEN (9.61e-13), SHBG (2.18e-07), and TP53 (2.18e-07).

In addition, a fraction of somatic SVs (2 breakpoints each; 1,328 breakpoints in total) overlapped with 156 driver genes reported as altered by significantly recurrent breakpoints in the PCAWG study, while using a generalised linear model with adjustable background covariates we identified an additional 100 genes to be significantly impacted by SV breakpoints (FDR=1.3e-43–0.097, Extended Data Fig. 3c, Supplementary Table 4). For over 20% of tumours, SV breakpoints coexisted with other mutational types within DNAH2, ERG, FAM66C, FXR2, PTEN, SHBG, and TP53. Using optical genome mapping (OGM), an alternative non-sequencing method to interrogate for chromosomal abnormalities, we validated recurrent breakpoints in novel HLA regions (DQA1 and DQB1 genes), identifying translocations between the...
3-Mb HLA complex at chromosome 6 and its corresponding HLA alternate contigs (Extended Data Fig. 3d).

**Integrative clustering analysis of molecular subtypes**

Molecular subtyping of tumours is a standard approach in cancer genomics to stratify patients into different degrees of somatic alterations in a homogeneous population, with an implication for clinical use\(^9\)-\(^12\). Identifying five of the seven TCGA oncogenic driver-defined subtypes in our study\(^7\), European patients were 25% more likely than African patients to be classified (Supplementary Table 5, Extended Data Fig. 4a-d). While TMPRSS2-ERG fusions (predominantly 3-Mb deletions) and FOXA1 coding mutations (forkhead domain) occurred at higher frequencies in our European over African patients, 37.7% and 8.2% *versus* 13.3% and 5.3%, respectively (OR=0.255, *P*-value=0.0004 and OR=0.854, *P*-value=0.771), SPOP coding mutations (MATH and BTB domains) were more common in the African (8.8%) *versus* European patients (6.6%, OR=1.688, *P*-value=0.426).

For further molecular classification, we performed iCluster analysis on all mutational types (small mutations, copy number and SVs) identifying four subtypes, A to D (Supplementary Table 6, Fig. 2a, b). We found Subtype A to be mutationally quiet (1.01 mutations/Mb, 0.50 breakpoints/10Mb, 2% PGA); conversely Subtype D showed the greatest mutational density (1.91 mutations/Mb, 1.08 breakpoints/10Mb, 31% PGA) with a mixture of copy number (CN) gains and losses, while Subtypes B and C were marked by substantial CN gains or losses, respectively (Fig. 3b). The quiet subtype seems to be common in prostate cancer studies\(^7\),\(^9\),\(^24\), while the number of pan-cancer consensus drivers\(^22\) increased from Subtype A (median, 2 drivers) to B (3), C (3) and D (4).
Using all mutational types in the analysis, 124 genes were significantly mutated across the four subtypes (FDR=3.742e-13–0.067; Fig. 3a), occurring in 31 to 183 patients (frequency, 0.17-1). Among them, 100 genes were reported as oncogenic drivers in the PCAWG\textsuperscript{22} and FOXA1 and SPOP genes acting as the TCGA subtypes were also replicated in this analysis, while the 24 novel recurrently mutated genes were predominantly impacted by SV breakpoints and CNAs. The median number of mutated genes ranged from 28 (range 3-105) for Subtype A to 82, 98 and 93 for Subtypes B, C and D, respectively (42-109, 72-112, 49-107). While different mutational types tended to co-occur within genes and/or patients (Supplementary Table 7), small mutations (coding and noncoding) were noticeably observed in the quiet subtype, supporting acquisition early in tumourigenesis\textsuperscript{25}. Our preferentially mutated genes within tumour subtypes resemble the long tail of prostate cancer drivers\textsuperscript{19}, with some highly impacting many tumours, but most only impacting a few tumours.

The 124 preferentially mutated genes within our tumour subtypes corresponded to eight TCGA/ICGC cancer pathways (see Supplementary Methods, Extended Data Fig. 5). While six showed slightly elevated mutational frequencies in African derived tumours, genes impacting epigenetic mechanisms were significantly biased towards Europeans (OR=0.179, $P$-value=2.9e-07, Extended Data Fig. 6b). Pathway enrichment analysis supported five functional networks of the cancer pathways, with two of them involved in signal transduction and DNA checkpoint processes to which five of the eight pathways were interacted (Extended Data Fig. 6a; Supplementary Table 8).

**Global molecular subtypes**
Through combining molecular profiling and patient demographics, ethnicity and geography, we identify a new prostate cancer taxonomy we define as ‘Global Mutational Subtypes (GMS)’ (Fig. 2b). While all European patients from Australia (n=53) and Brazil (n=3) were limited to GMS-A and C, African derived tumours were dispersed across all four subtypes. We found GMS-B and D to predominate in Africans, with GMS-B including a single patient of admixed ancestry (92% African) and GMS-D including a single admixed (63% African) and a single European ancestral patient. The latter was one of only five Europeans in our study born and raised in Africa. Compared to other patients of European ancestry, this patient showed the highest mutational density across all types. Alternative consensus clustering of individual mutational types mostly recapitulated the subtypes by integrative analysis (Supplementary Table 6). Through further inclusion of Chinese Asian high-risk prostate cancer data\(^{12}\) (n=93, Extended Data Fig. 7a), we found GMS-A to be ethnically and geographically ‘universal’, while GMS-D remained ‘African-specific’ with a new ‘African-Asian’ GMS-E emerging. GMS-B remained ‘African-specific’ and GMS-C ‘European-African’. While all patients were treatment naïve at the time of sampling, our European cohort was recruited with extensive follow-up data (median±s.d., 122.5±44.4 months). Interestingly, biochemical relapse (Fig. 3c) and death-free survival probability (Fig. 3d) explains better clinical outcomes for patients presenting with the ‘universal’ over the ‘European-African’ GMS (A \textit{versus} C, log-rank \(P\)-value=0.008 and 0.041, respectively).

Our novel GMS taxonomy could leverage pan-cancer studies in the following ways. First, a sampling strategy of patients from the PCAWG project was rather homogeneous in each cancer, therefore inhibiting the discovery of globally restricted subtypes\(^{3,14}\) (Extended Data Fig. 7b). Second, ancestral\(^{26}\) and geographic data of
patients should be included in molecular profiling of cancers. Lastly, the inclusion of ethnic disparity in cancer studies would need to properly address admixture in a sampling cohort, with too low ancestral cut-off appearing to create highly admixed, but similar ancestry among individuals, therefore discouraging ethnically diverse samples.

Novel and known mutational signatures

Approximating the contribution of mutational signatures to individual cancer genomes facilitates an association of the signatures to exogenous or endogenous mutagen exposures that contribute to the development of human cancer. Here, we generated a novel list of copy number (CN) and SV signatures and their contributions to prostate cancer using nonnegative matrix factorisation (Extended Data Fig. 8a, b). Combined with a known catalogue of small mutational signatures, including single base substitutions (SBS), doublet base substitutions (DBS) and small insertions and deletions (ID), we observed not only a substantial variation in the number of mutational features, but also over-representation in African derived tumours (Extended Data Fig. 8c). Overall, 96 SBS, 78 DBS and 83 ID features examined had significantly higher totals in Africans (SBS, 3,399 \textit{versus} 2,840 in Europeans, \(P\)-value=0.014; DBS, 42 \textit{versus} 32, \(P\)-value=0.006; ID, 374 \textit{versus} 360, \(P\)-value=0.016, two-sample t-test). We generated six \textit{de novo} signatures for each small signature type (median cosine similarity 0.986, 0.856, and 0.976, respectively), corresponding to 12, seven and eight global signatures, respectively (0.966, 0.850, and 0.946, respectively; Extended Data Fig. 9), with 26 likely to be of biological origin (SBS47, possible sequencing artefacts). DBS substitutions accounted for about 1% of the prevalence of SBS. The CN features were also greater in Africans (CN, 3,971 \textit{versus} 2,721, \(P\)-
value=1.92e-08; SV, 94 versus 88, \( P\)-value=0.100). The SV features defined in a recent pan-cancer study\(^2\) were each mutually exclusive and included simple SVs (split according to size, replication timing and occurrence at fragile sites), templated insertions (split by size), local n-jumps and local–distant clusters. The factorisation of a sample-by-mutation spectrum matrix identified six CN signatures (CN1-6) and eight SV signatures (SV1-8), as well as their contributions to each tumour.

We found the full spectrum of mutational signatures (SBS, DBS, ID, CN and SV) to support our newly described GMS. Enrichment records of the top signatures in each tumour were significantly associated type by type with the taxonomic subtypes, except for DBS \( (P\)-values=5.1e-07–0.017, one-way ANOVA or Fisher’s exact test, Extended Data Fig. 8d). Regardless of signature type, 13/40 mutational signatures showed either inverse or proportionate correlations with our GMS \( \text{FDR}=4.97e-13–0.095, \text{Spearman’s correlation, Fig. 4} \). Duplication signatures, including CN1 (tandem duplication), CN4 (whole genome duplication), SV2 (insertion) and SV5 (large duplication), were biased to the most mutationally noisy subtype (Extended Data Fig. 8a, b), with CN4 and SV5 frequent in Africans \( \rho=-0.24, \text{FDR}=0.005-0.006 \). The mutational density of 30 out of 32 genes highly mutated in our GMS and reported in prostate cancer was also significantly correlated with different somatic signatures, with most observed in CN2, CN6 and SV6 signatures that were mainly caused by deleted genomes. Small-size signatures were inversely significant among 20 mutated genes, indicating a higher number of mutations towards lesser mutated tumours \( \text{FDR}=1.05e-08–0.099 \).

Life history of globally mutated subtypes
Timeline estimates of individual somatic events reflect evolutionary periods that differ from one patient to another; for example, a cluster of identical alterations derived from clones in one patient presented as subclonal events in another patient (Extended Data Fig. 10a, b). However, they provide in part the order of driver mutations and CNAs present in each sample. The reconstruction of aggregating single-sample ordering of all drivers and CNAs reveals different evolutionary patterns unique to each GMS (Extended Data Fig. 10c, Fig. 5a, b). We draw approximate cancer timelines for each GMS portraying the ordering of driver genes, recurrent CNAs and signature activities chronologically interleaved with whole-genome duplication (WGD) and the emergence of the most recent common ancestor (MRCA) leading up to diagnosis. Basically, significantly co-occurring interactions of the drivers and CNAs are shown (OR=2.6–97.8, \( P \)-values = 2.04e-30–0.01), supporting their clonal and subclonal ordering states within the reconstructed timelines. SBS and ID signatures that are abundant in each GMS display changes of their mutational spectrum between the clonal and subclonal state, suggesting a difference in mutation rates. The plot of clock-like CpG-to-TpG mutations and patient age adjustment shows the median mutation rate as little as 0.968 per year for the ‘universal’ GMS, but the highest rate at 1.315 per year observed in the ‘African-specific’ GMS-D. GMS-B and C have rates of 1.144 and 1.092 per year, respectively. Assessing the relative timing of somatic driver events, \( TP53 \) mutations and accompanying 17p loss are of particular interest, occurring early in GMS-C progression and at a later stage in GMS-A. League model relative timing of driver events (see Supplementary Methods) is in line with a fraction of probability distribution of the \( TP53 \) alterations at the early stage, but most are at an intermediate state of evolution (Extended Data Fig. 10d). This basic knowledge of \textit{in vivo} tumour development suggests that some tumours could have a
shorter latency period before reaching their malignant potential, so known genomic heterogeneity of their primary clones is paramount to pave a way for early detection.

**Discussion**

To our knowledge, our study represents the first, if not, the largest whole-genome prostate cancer, and likely any cancer, genome resource for Sub-Saharan Africa. Here we describe a novel prostate cancer molecular taxonomy, identifying ethnically and geographically distinctive Global Mutational Subtypes (GMS). Compared to previous taxonomy using significantly mutated genes in prostate cancer \(^7,19\), we found GMS to compliment known subtypes such as *SPOP* and *FOXA1* mutations, in contrast to underrepresented subtypes in this study, including gene fusions (Extended Data Fig. 4a). We also found GMS to correlate with mutational signatures reported in the known catalogue of somatic mutations in cancer, where each tumour is represented by different degrees of exogenous and endogenous mutagen exposures \(^3\). Our study has leveraged the analysis of evolution across 38 cancer types by the PCAWG Consortium \(^25\), recognising that each GMS represents a unique evolutionary history with drivers and mutational signatures varied between cancer stages and linking somatic evolution to a patient’s demographics. Therefore, some represent ‘rare or geographically restricted signatures’ that are still a myth in pan-cancer studies \(^3,14\).

We consider two extreme cases, ‘universal’ GMS-A *versus* ‘African-specific’ GMS-B and D, that would have been influenced by two different mutational processes for conceptual simplicity (Fig. 5c). One is predisposing genetic factors that are known for prostate tumourigenesis across ethnolinguistic groups \(^28-30\). This factor contributes to endogenous mutational processes, especially those with significant germline-somatic interactions, such as the *TMPRSS2-ERG* fusion less frequently observed in men of
African and Asian ancestry, germline BRCA2 mutations and the somatic SPOP driver co-occurred with their respective counterparts. Another factor is modifiable environmental attributes specific to certain circumstances or geographic regions that, until now, have been elusive to prostate cancer. They act as mutagenic forces leading to the positive selection of point mutations throughout life in healthy tissues and cancers, forming fluid boundaries between normal ageing and cancer tissues.

According to Ottman, the above-mentioned model of gene-environment interaction is observed when there is a different effect of a genotype on disease in individuals with different environmental exposures or, alternatively, a different effect of an environmental exposure on disease in individuals with different genotypes. Other GMS subtypes would be a combination of the two processes, warranting a need for larger populations of different ethnicities from different geographical localities to be studied for a breakthrough in nature versus nurture. As such, the study directly accounts for the large spatio-genomic heterogeneity of prostate cancer and its associated evolutionary history in understanding the disease aetiology.

Our study suggests that larger genomic datasets of ethnically and geographically diverse populations in a unified analysis will continue to identify rare and geographically restricted subtypes in prostate cancer and potentially other cancers. We are the first to demonstrate that ancestral and geographic attributes of patients could facilitate those studies on cancer population genomics, an alternative to cancer personalised genomics, for a better scientific understanding of nature versus nurture.
**Figure legends**

**Fig. 1 | Mutational density in prostate tumours of different ancestries.** a, Distribution of somatic aberration (event number or number of base pairs) for seven mutational types across 183 tumour-blood WGS pairs. b, Different types of mutational burden observed in this cohort. Samples are percentile ranked and then ordered based on the sum of percentiles across the mutational types observed in each ethnic group (left panel). Spearman’s correlation is shown between mutation types, with dot size representing the magnitude of correlation and background colour giving statistical significance of FDR values (right panel).

**Fig. 2 | Prostate cancer taxonomy of ethnically diverse populations.** a, Integrative clustering analysis reveals four distinct molecular subtypes of prostate cancer. The molecular subtypes are illustrated by small somatic mutations (coding regions and noncoding elements), somatic copy number alterations and somatic SVs. The percentage and association between the iCluster membership and patient ancestry are illustrated in square brackets. A, African ancestry; Ad, Admixed; and E, European ancestry. b, Total somatic mutations across four molecular subtypes in this study. Dashed lines indicate the median values of mutational densities across the four subtypes. For each subtype, patients are ordered based on their ethnicity.

**Fig. 3 | Aberration of driver genes in four diverse subtypes.** a, Analysis of the long tail of driver genes using different mutation data combined. A total of 124 genes are associated with four prostate cancer subtypes, and all have previously been reported as significantly recurrent mutations/SV breakpoints in the PCAWG Consortium\(^22\), except for ones marked by asterisks, where they are assigned to be significantly mutated using whole-genome data in this study. The Y-axis shows corrected \(P\)-values in \(-\log_{10} P\). CDS, coding driver data; NC, noncoding driver data; SV, significantly recurrent breakpoint data; and CN, gene-level copy number data. b, Unsupervised hierarchical clustering of known and putative driver genes identified within four prostate cancer subtypes (A-D, a bottom-up direction). Rows are patients, and columns represent 124 driver genes (alphabetical order) identified using different mutational types. c, Kaplan-Meier plot of biochemical relapse (BCR)-free survival proportion of European patients in subtype A (\(n=161\)) versus C (\(n=19\)). d, Kaplan-Meier plot of cancer survival probability of European patients in subtype A (\(n=82\)) versus C (\(n=17\)).
Fig. 4 | **Estimates of genomic aberrations contributed by each mutational signature.** The size of each dot represents FDR values of Spearman correlation $P$-values using BH correction. The colours of each dot represent correlation coefficient (rho). GMS is assigned as 1-4 for Subtypes A-D, respectively; African, Admixed and European are recorded as 1-3, respectively. The correlation of 32 significantly mutated genes in prostate cancer is shown in the X-axis.

Fig. 5 | **Evolutionary history of globally mutated subtypes.** a, The cancer timeline of the universal subtype begins from the fertilised egg to the age of the patients at a cohort. b, that of GMS-C. Estimates for major events, such as WGD (whole-genome duplication) and the emergence of the MRCA (the most recent common ancestor), are used to define early, variable, late and subclonal stages of tumour evolution approximately in chronological time. When early and late clonal stages are uncertain, the variable stage is assigned. The variable/constant time period includes events that are ranked before the WGD event and also begins shortly after another break in the timeline. The late period does have a definite start, as this includes events that are ranked after WGD, when it occurs. Driver genes and CNAs are shown in each stage if present in previous studies and defined by MutationTime.R program. Mutational signatures (Sigs) that, on average, change over the course of tumour evolution, or are substantially active but not changing, are shown in the epoch in which their activity is rather greatest. Dagger symbols denote alterations that are found to have different timing. Significant pairwise interaction events between the mutations and copy number alterations were computed using Odds Ratio (OR). Either co-occurrence or mutually exclusive event is considered if OR $>2$ or $<0.5$, respectively. Median mutation rates of CpG-to-TpG burden per Gb are calculated using age-adjusted branch length of cancer clones and maximally branching subclones. c, Schematic representation of a world map with the distribution of GMS (A–D) among ethnically/globally diverse populations. The gene-environment interaction model of globally mutated subtypes is shown in the right panel. The contingency table of number of patients with different ancestries (germline variants) stratified by subtypes and associated with certain geography or environmental exposure (two-sided $P$-value $= 0.0005$, Fisher’s exact test with 2,000 bootstraps).
Methods

Patient cohorts and whole-genome sequencing

Our study included ~180 treatment naïve prostate cancer patients recruited under informed consent and appropriate ethics approval (Supplementary Methods, Section 2) from Australia (n=53), Brazil (n=7) and South Africa (n=123). DNA extracted from fresh tissue and matched blood underwent 2x150 bp sequencing on the Illumina NovaSeq instrument (Kinghorn Centre for Clinical Genomics, Garvan Institute of Medical Research).

WGS processing and variant calling

Each lane of raw sequencing reads was aligned against human reference hg38 + alternate contigs using bwa v0.7.1538. Lane-level BAMs from the same library were merged, and duplicate reads were marked. The Genome Analysis Toolkit (GATK v4.1.2.0) was used for base quality recalibration39. Contaminated and duplicate samples (n=8) were removed. We implemented three main pipelines for the discovery of germline and somatic variants, with the latter including small (SNV and indel) to large genomic variation (CN and SV). Complete pipelines and tools used are available from the Sydney Informatics Hub (SIH), Core Research Facilities, University of Sydney (see Code availability). Scalable bioinformatic workflows are described in Supplementary Methods, Section 4.

Genetic ancestry was estimated using fastSTRUCTURE v1.040, Bayesian inference for the best approximation of marginal likelihood of a very large variant dataset. Reference panels for African and European ancestry compared in this study were retrieved from previous whole-genome databases20,21.
Analysis of chromothripsis and chromoplexy

Clustered genomic rearrangements of prostate tumours were identified using ShatterSeek v0.4\textsuperscript{41} and ChainFinder v1.0.1\textsuperscript{42}. Our somatic SV and somatic CNA callsets were prepared and co-analysed using custom scripts (see Code availability, Supplementary Methods, Section 6).

Analysis of mutational recurrence

We used three approaches to detect recurrently mutated genes or regions based on three mutational types, including small mutations, SVs and CNAs (see Supplementary Methods, Section 7). In brief, small mutations were tested within a given genomic element as being significantly more mutated than adjacent background sequences.

The genomic elements retrieved from syn5259886, the PCAWG Consortium\textsuperscript{22} were a group of coding sequences and 10 groups of noncoding regions. SV breakpoints were tested in a given gene for their statistical enrichment using Gamma-Poisson regression and corrected by genomic covariates\textsuperscript{13}. Focal and arm-level recurrent CNAs were examined using GISTIC v2.0.23\textsuperscript{43}. Known driver mutations in coding and noncoding regions published in PCAWG\textsuperscript{22,44,45} were additionally recorded in our 183 tumours, and those specific to prostate cancer genes were also included\textsuperscript{7,8,13,18,19}.

Integrative analysis of prostate cancer subtypes

Integrative clustering of three genomic data types for 183 patients was performed using iClusterplus\textsuperscript{12,46} in R, with the following inputs: \textit{i}) driver genes and elements; \textit{ii}) somatic CN segments; and \textit{iii}) significantly recurrent SV breakpoints. We ran iClusterPlus.tune with clusters ranging from 1-9. We also performed unsupervised consensus clustering on each of the three data types individually. Association analysis
of genomic alteration with different iCluster subtypes was performed in detail in
Supplementary Methods, Section 8. Differences in drivers, recurrent breakpoints and
somatic CNAs across different iCluster subtypes were reported.

**Comparison of iCluster with Asian and pan-cancer data**

To compare molecular subtypes between extant human populations, the Chinese
Prostate Cancer Genome and Epigenome Atlas (CPGEA, PRJCA001124)\(^2\) was
merged and processed with our integrative clustering analysis across the three data
types described above, with some modifications. Moreover, we leveraged the
PCAWG Consortium\(^1\)\(^4\) to define molecular subtypes across different ethnic groups in
other cancer types using published data of somatic mutations, SV and GISTIC results
by gene. Four cancer types that consisted of breast, liver, ovarian, and pancreatic
cancers were considered due to existing primary ancestries of African, Asian and
European with at least 70% contribution. Full details are given in Supplementary
Methods, section 8.4.

Prostate cancer subjects of PCAWG\(^1\)\(^4\) were retrieved to compare with Australian data
with clinical follow-up. Only those of European ancestry greater than 90% (n=139)
were analysed for the three genomic data types of iCluster subtyping, as well as
individual consensus clustering. Clustering results identical to the larger cohort size
mentioned above were chosen for association analyses. Differences in the
biochemical relapse and lethal prostate cancer of the subjects across the subtypes
were assessed using the Kaplan–Meier plot followed by a log-rank test for
significance.

**Analysis of mutational signatures**
Mutational signatures (SBS, DBS and ID), as defined by the PCAWG Mutational Signatures Working Group\(^3\), were fit to individual tumours with observed signature activity using SigProfiler\(^47\). Nonnegative matrix factorisation (NMF) was implemented to detect de novo and global signature profiles among 183 patients and their contributions. Novel mutational genome rearrangement signatures (CN and SV) were also performed using the NMF, with 45 CN and 44 SV features examined across 183 tumours. We followed the PCAWG working classification and annotation scheme for genomic rearrangement\(^27\). Two SV callers were used to obtain exact breakpoint coordinates. Replication timing scores influencing on SV detection were set at >75, 20-75, and <20 for early, mid, and late timing, respectively\(^48\). Full details of analysis steps, parameters and relevant statistical tests are given in Supplementary Methods, Section 9.

**Reconstruction of cancer timelines**

Timing of copy number gains and driver mutations (SNVs and indels) into four epochs of cancer evolution (early clonal, unspecified clonal, late clonal, and subclonal) was conducted using MutationTimeR\(^25\). CN gains including 2+0, 2+1, and 2+2 (1+1 for a diploid genome) were considered for a clearer boundary between epochs instead of solely information of variant allele frequency. Confidence intervals \((t_{lo} – t_{up})\) for timing estimates were calculated with 200 bootstraps. Mutation rates for each subtype were calculated following Gerstung, et al\(^25\) that CpG-to-TpG mutations were counted for the analysis because they were attributed to spontaneous deamination of 5-methyl-cytosine to thymine at CpG dinucleotides, therefore acting as a molecular clock.
League model relative ordering was performed to aggregate across all study samples to calculate the overall ranking of driver mutations and recurrent CNAs. The information for the ranking was derived from the timing of each driver mutation and that of clonal and subclonal CN segments, as described above. Full description is provided in Supplementary Methods, Section 10.

**Data availability**

Alignments, somatic and germline variant calls, annotations and derived datasets are available for general research use for browsing and download through the European Genome-Phenome Archive (accession number EGA0000000000). Other supporting data are available upon request from the corresponding author.

**Code availability**

The core computational pipelines used in this study for read alignment, quality control and variant calling are available to the public at [https://github.com/Sydney-Informatics-Hub/Bioinformatics](https://github.com/Sydney-Informatics-Hub/Bioinformatics). Analysis code for chromothripsis and chromoplexy is available through another GitHub page, [https://github.com/tgong1/Code_HRPCa](https://github.com/tgong1/Code_HRPCa).

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(retired) and Dr Smit van Zyl, previously from the University of Limpopo, South Africa, for their critical contributions as inaugural members of the SAPCS.

**Authors' contributions**

V.M.H. designed the experiments and supervised the project; W.J. led the bioinformatic and statistical analyses, while both W.J. and V.M.H. performed data interpretation. S.M.P., R.J.L., A-M.H., and D.G.P. prepared the samples and managed phenotypic data. M.L. and J.G.K. performed pathological grading, while R.C., L.G.H., I.S.B., S.B.A.M., P.D.S. and M.S.R.B. managed patient recruitments and consents, as well as clinical interpretation. V.M.H., S.B.A.M. and M.S.R.B. codirect the Southern African Prostate Cancer Study (SAPCS). W.J., J.J., T.G., C.W., T.C. and R.S. developed the pipelines and performed the efficient and scalable high-performance computational variant calling, with critical advice provided by E.K.F.C and V.M.H. W.J., J.J. and T.G. performed complex variant annotation, while R.J.L. generated the optical genome mapping (OGM) data. W.J. performed mutational signature and tumour evolution analysis, with critical advice provided by D.C.W. W.J. and V.M.H. wrote the manuscript. W.J. generated the figures, while all authors contributed to the final editing and approval.

**Competing interest declaration**

The authors declare no competing interests.
Supplementary Tables

Supplementary Table 1 | Clinical cohort characteristics and sequencing quality

Supplementary Table 2 | Driver information by patient

Supplementary Table 3 | GISTIC2 results of all genomic lesions under 99% confidence level

Supplementary Table 4 | List of significantly recurrent SV breakpoints at FDR lower than 0.10

Supplementary Table 5 | TCGA prostate cancer taxonomy identified in this study

Patient by driver mutation and patient by driver structural variation summary matrices are provided.

Supplementary Table 6 | Integrative iCluster analysis of 183 prostate tumours

Supplementary Table 7 | List of 124 preferentially mutated genes within four tumour subtypes

Supplementary Table 8 | Pathway enrichment analysis of 124 preferentially mutated genes

Supplementary Table 9 | Total mutational signature profiles across 183 tumours

The table shows data matrices of SBS feature by patient, DBS feature by patient, ID feature by patient, CN feature by patient, and SV feature by patient.

Supplementary Table 10 | Cross-individual contamination level

Supplementary Table 11 | Cancer evolution analysis of prostate cancer

Clonal architecture by PhyloWGS and timing of gains and drivers by MutationTimeR is provided per tumour.

Supplementary Table 12 | Other relevant data and analyses
Extended data legends

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**Fig. 1 | Mutational density in prostate tumours of different ancestries.**

**a,** Distribution of somatic aberration (event number or number of base pairs) for seven mutational types across 183 tumour-blood WGS pairs. **b,** Different types of mutational burden observed in this cohort. Samples are percentile ranked and then ordered based on the sum of percentiles across the mutational types observed in each ethnic group (left panel). Spearman’s correlation is shown between mutation types, with dot size representing the magnitude of correlation and background colour giving statistical significance of FDR values (right panel).
Fig. 2 | Prostate cancer taxonomy of ethnically diverse populations. a, Integrative clustering analysis reveals four distinct molecular subtypes of prostate cancer. The molecular subtypes are illustrated by small somatic mutations (coding regions and noncoding elements), somatic copy number alterations and somatic SVs. The percentage and association between the iCluster membership and patient ancestry are illustrated in square brackets. A, African ancestry; Ad, Admixed; and E, European ancestry. b, Total somatic mutations across four molecular subtypes in this study. Dashed lines indicate the median values of mutational densities across the four subtypes. For each subtype, patients are ordered based on their ethnicity.
Fig. 3 | Aberration of driver genes in four diverse subtypes. a, Analysis of the long tail of driver genes using different mutation data combined. A total of 124 genes are associated with four prostate cancer subtypes, and all have previously been reported as significantly recurrent mutations/SV breakpoints in the PCAWG Consortium, except for ones marked by asterisks, where they are assigned to be significantly mutated using whole-genome data in this study. The Y-axis shows corrected P-values in $-\log_{10} P$. CDS, coding driver data; NC, noncoding driver data; SV, significantly recurrent breakpoint data; and CN, gene-level copy number data. b, Unsupervised hierarchical clustering of known and putative driver genes identified within four prostate cancer subtypes (A-D, a bottom-up direction). Rows are patients, and columns represent 124 driver genes (alphabetical order) identified using different mutational types. c, Kaplan-Meier plot of biochemical relapse (BCR)-free survival proportion of European patients in subtype A (n=161) versus C (n=19). d, Kaplan-Meier plot of cancer survival probability of European patients in subtype A (n=82) versus C (n=17).
**Fig. 4 | Estimates of genomic aberrations contributed by each mutational signature.** The size of each dot represents FDR values of Spearman correlation $P$-values using BH correction. The colours of each dot represent correlation coefficient (rho). GMS is assigned as 1-4 for Subtypes A-D, respectively; African, Admixed and European are recorded as 1-3, respectively. The correlation of 32 significantly mutated genes in prostate cancer is shown in the X-axis.
**Fig. 5 | Evolutionary history of globally mutated subtypes.**

**a.** The cancer timeline of the universal subtype begins from the fertilised egg to the age of the patients at a cohort. **b.** that of GMS-C.

Estimates for major events, such as WGD (whole-genome duplication) and the emergence of the MRCA (the most recent common ancestor), are used to define early, variable, late and subclonal stages.
of tumour evolution approximately in chronological time. When early and late clonal stages are
uncertain, the variable stage is assigned. The variable/constant time period includes events that are
ranked before the WGD event and also begins shortly after another break in the timeline. The late
period does have a definite start, as this includes events that are ranked after WGD, when it occurs.

Driver genes and CNAs are shown in each stage if present in previous studies and defined by
MutationTime.R program. Mutational signatures (Sigs) that, on average, change over the course of
tumour evolution, or are substantially active but not changing, are shown in the epoch in which their
activity is rather greatest. Dagger symbols denote alterations that are found to have different timing.

Significant pairwise interaction events between the mutations and copy number alterations were
computed using Odds Ratio (OR). Either co-occurrence or mutually exclusive event is considered if
OR >2 or <0.5, respectively. Median mutation rates of CpG-to-TpG burden per Gb are calculated using
age-adjusted branch length of cancer clones and maximally branching subclones. Schematic
representation of a world map with the distribution of GMS (A–D) among ethnically/globally diverse
populations. The gene-environment interaction model of globally mutated subtypes is shown in the
right panel. The contingency table of number of patients with different ancestries (germline variants)
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Supplementary Files

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- S1Clinicalcohortcharacteristicsandsequencingquality.xlsx
- S2Driverinformationbypatient.xlsx
- S3GISTIC2resultsofallgenomiclesionsunder99Xconfidencelevel.xlsx
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