Increasing Stemness Drives Prostate Cancer Progression, Plasticity, Therapy Resistance and Poor Patient Survival

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ABSTRACT

Cancer progression involves loss of differentiation and acquisition of stem cell-like traits, broadly referred to as “stemness”. Here, we test whether the level of stemness, assessed by a transcriptome-derived Stemness score, can quantitatively track prostate cancer (PCa) development, progression, therapy resistance, metastasis, plasticity, and patient survival. Integrative analysis of 3,102 RNA-seq and 84,081 microarray samples across 26 datasets reveals a progressive increase in Stemness and decline in pro-differentiation androgen receptor activity (AR-A) along the PCa continuum, with metastatic castration-resistant PCa (mCRPC) exhibiting the highest Stemness and lowest AR-A. Both the general Stemness score and a newly developed 12-gene “PCa-Stem Signature” correlate with and predict poor clinical outcomes. Mechanistically, increased AR-A may promote Stemness in early-stage PCa while *MYC* amplification and bi-allelic *RB1* loss likely drive greatly elevated Stemness in mCRPC where AR-A is suppressed. Our findings establish Stemness as a robust quantitative measure of PCa aggressiveness and offer a scalable framework for PCa risk stratification.

INTRODUCTION

Malignant transformation and cancer progression are characterized by progressive loss of differentiation (or oncogenic dedifferentiation) and gain of stem cell traits (i.e., stemness), and poorly differentiated tumors are enriched in gene expression profiles of normal embryonic and adult stem cells and in cancer stem cells[1, 2, 3, 4, 5]. However, the oncogenic dedifferentiation-based stemness concept[6] that prostate cancer (PCa) represents abnormal organogenesis[7,8] is not currently addressed and there lack quantitative measurements of the overall stemness-associated aggressiveness in PCa.

PCa is projected to claim the lives of >35,000 American men in 2025[9]. PCa incidence rates increased 3% per year from 2014 - 2019 driven by advanced PCa diagnosis and the proportion of men diagnosed with metastases has doubled from 2011 to 2019 when the next generation of androgen receptor (AR) pathway inhibitors (ARPIs) such as abiraterone (Zytiga; FDA approval in 2011) and enzalutamide (Xtandi; FDA approval in 2012) were introduced to the clinic. Significant increases in aggressive disease and continued high PCa mortality have been linked to intrinsic PCa cell heterogeneity (e.g., in AR expression) and treatment-induced plasticity[8].

The level of malignancy of primary PCa (Pri-PCa) has been traditionally assessed by pathologists using a combined Gleason Score (GS), which gauges histopathological differentiation pattern of prostatic glands. The higher the GS, the more undifferentiated and more malignant the Pri-PCa is. The GS system, although clinically the 'gold' standard in pinpointing PCa diagnosis, is only semi-quantitative, can be subjective (to individual pathologist's assessment), and is generally not applicable to treatment-failed tumors and distant metastases (which have mostly lost differentiated glandular structures). Notably, whether more advanced Pri-PCa (GS8-10), treatment failure and metastatic dissemination are quantitatively associated with increased cancer stemness remains unknown. On the other hand, AR is the master regulator of normal prostatic epithelium differentiation and represents the therapeutic target of PCa treatments including androgen-deprivation therapy (ADT) and ARPIs. Inevitably, tumors develop resistance to ADT/ARPIs leading to the state of castration-resistant PCa (CRPC), which involves many mechanisms including genetic alterations of *AR* and key genes in AR pathway[10], lineage plasticity[8,11,12], and increased stemness[8,13]. It is unclear how the global pro-differentiation AR signaling activity changes and evolves during the spectrum of PCa initiation and progression and during development of treatment resistance and metastasis. These discussions raise the need to quantify the AR signaling and stemness and closely track their dynamic evolution and inter-relationship during PCa progression.

Herein, we adapted and developed transcriptome-based gene signature scores to quantitatively assess the pro-differentiation (canonical) AR activity (AR-A) and oncogenic stemness levels (Stemness Index or

85 Score) and their inter-relationship in the PCa spectrum. Specifically, we used gene expression data
86 collected from 3,102 RNA-seq and 84,081 microarray samples in 26 distinct cohorts encompassing the
87 PCa continuum, i.e., from normal/benign prostate to early stage, advanced and metastatic PCa, to pre-
88 and post-therapy PCa, and, finally, mCRPC, to track the dynamic evolution of and inter-relationship
89 between AR-A and the Stemness Index. Our results indicate that increased Stemness quantitatively tracks
90 PCa aggressiveness, plasticity, treatment resistance and progression, and represents a poor prognostic
91 factor for patient outcomes.

92 **RESULTS**
93

94 **Adapting and developing Stemness and AR-A metrics for PCa analysis.**
95 To determine the global and dynamic changes of and inter-relationship between degree of malignancy
96 (oncogenic dedifferentiation) and level of (luminal) differentiation during PCa development and progression
97 (Supplementary Fig. S1A-B), we employed two transcriptome-based algorithms to annotate 26 datasets
98 of 3,102 bulk RNA-seq and 84,081 microarray samples encompassing the PCa continuum (Supplementary
99 Fig. S1B; Supplementary Table S1). In our studies, we focused on and compared three progressive stages:
100 from normal prostate to localized Pri-PCa, from low-grade to high-grade Pri-PCa, and from treatment-naïve
101 Pri-PCa to CRPC/mCRPC (Supplementary Fig. S1A). We defined "progression" as stages beyond Pri-
102 PCa and as disease entities that are more aggressive in a comparative manner. Specifically, we adapted
103 the Stemness Index[6] (mRNAsi; **Stemness** for short) (Supplementary Fig. S1C) to gauge the degree of
104 malignancy (or aggressiveness) and employed the Z-score normalized canonical (pro-differentiation) AR
105 activity or **AR-A** (Supplementary Fig. S1D) to measure the level of differentiation. Canonical AR-A can be
106 determined by quantifying AR-regulated transcripts under intact androgen/AR signaling conditions, and
107 there are several such AR-regulated gene lists[14, 15, 16, 17, 18] (Supplementary Fig. S2A-B). We validated the
108 AR-A list based on their enrichment in prostatic epithelium differentiation, correlation of individual gene
109 expression with AR-A signatures in clinical datasets, and overall consistency in correlation among the AR-
110 A scores (Supplementary Fig. S2B-D). Given that Bluemn's AR-A score[14] correlated well with other scores
111 (Supplementary Fig. S2E-G) and the 10 genes in this signature consistently represented AR targets in
112 multiple clinical datasets (Supplementary Fig. S2D; Supplementary Table S2), we decided to use this AR-
113 regulated gene list for our AR-A quantification.
114

115 **Normal prostate epithelium shows a negative correlation between Stemness and AR-A.**
116 The normal human prostate (NHP) comprises 2 major epithelial types: basal and luminal cells
117 (Supplementary Fig. S3A). We annotated two studies that profiled FACS-purified NHP luminal and basal
118 cell populations[19, 20] and observed that the luminal cell population (Trop2^{+}CD49f^{lo}) possessed higher *AR*
119 mRNA levels and AR-A but lower Stemness compared to basal cells (Trop2^{+}CD49f^{hi}) and, in both datasets,
120 AR-A negatively correlated with Stemness (Supplementary Fig. S3B-C). These results support that the
121 NHP basal cell compartment harbors primitive stem cells[7, 19, 20, 21, 22] and AR-A measures the level of
122 prostate epithelial differentiation.
123

124 **Pri-PCa exhibits concordantly increased Stemness and AR-A, and neoadjuvant ADT (nADT)**
125 **decreases both Stemness and AR-A.**
126 In analyzing AR-A and Stemness in matched pairs of prostate tumor (T) and normal (N; tumor-adjacent
127 benign) tissues in the TCGA-PRAD[18] (n=51 pairs), Wyatt 2014[23] (n=12 pairs), and Long 2020[24] (n=10 pairs)

128 cohorts, we observed concordantly increased AR-A and Stemness (Fig. 1A-C). Accompanying elevated
129 AR-A, *AR* mRNA levels were also increased in Pri-PCa compared to benign tissue (Fig. 1A-C; note that
130 the increase in *AR* mRNA levels in the Long 2020 cohort approached statistical significance). The paired
131 T/N comparisons (Fig. 1A-C) suggest that early PCa initiation and growth are characterized by
132 concordantly increased Stemness and AR-A. To test whether AR-A might causally drive increased
133 Stemness early during prostate tumorigenesis, we investigated 4 PCa nADT (i.e., ~2-6 months of ADT
134 before prostatectomy or radiation) cohorts[24, 25, 26]. In the first 3 cohorts with matched pairs of pre- and post-
135 nADT samples (from the same patients), nADT concordantly downregulated AR-A (without decreasing *AR*
136 mRNA levels) as well as the Stemness (Fig. 1D-F). In the Nastiuk cohort with non-paired post-nADT and
137 no-nADT samples (i.e., from different patients but matched for ages and tumor grades and stages), nADT
138 increased *AR* mRNA levels (Supplementary Fig. S4A) but reduced both AR-A and Stemness
139 (Supplementary Fig. S4B-C).
140
141 **Pri-PCa progression is accompanied by reduced AR-A but continually increasing Stemness.**
142 We next assessed the dynamic changes of Stemness and AR-A during *spontaneous* (i.e., therapy-free)
143 Pri-PCa progression (Fig. 2). To this end, we sorted out treatment-naïve tumors in TCGA-PRAD by
144 excluding samples from patients who received adjuvant (post-surgery) hormone therapy (i.e., Pri-PCa/ADT
145 or Tx; n=70) (Fig. 2A) and grouped the Pri-PCa samples according to increasing GS (Fig. 2B-D). When
146 compared with the 52 benign (N) samples, all the four GS groups from Pri-PCa (GS6, GS7, GS8, and
147 GS9/10 combined) showed higher AR-A and Stemness (Fig. 2C-D), consistent with the results in pairwise
148 T/N comparisons (Fig. 1A-C). However, when compared to GS6 PCa, the three higher GS groups showed
149 increasing *AR* mRNA levels (Fig. 2B) but decreasing AR-A (Fig. 2C) and increasing Stemness (Fig. 2D).
150 Jonckheere-Terpstra's (J-T) trend test validated a gradual reduction in canonical (pro-differentiation) AR
151 signaling but an increasing trend of Stemness with Pri-PCa progression (Fig. 2C-D). Notably, although we
152 observed a modest positive correlation between AR-A and Stemness in pooled Pri-PCa samples
153 (Pearson's r=0.27; Fig. 2E), this positive correlation gradually diminished with PCa progression when we
154 categorized the samples by tumor grade (Fig. 2F). The linear regression analysis confirmed that the
155 interaction between Stemness and AR-A significantly depended on tumor grade (P=0.0003), with a linear
156 decrease in the slope of the correlation as GS increased (Fig. 2G).
157 Collectively, these results indicate that, in contrast to early tumorigenesis, *spontaneous PCa*
158 *progression (i.e., with increasing GS and tumor grade) is marked by a divergence between oncogenic*
159 *Stemness and pro-differentiation AR-A*.
160
161
162

163 **Therapies and metastatic progression drive further divergence between attenuated AR-A and**
164 **increased Stemness.**
165 Next, we asked how clinical treatment and metastatic progression may impact the Stemness and AR-A by
166 querying untreated Pri-PCa and Pri-PCa/ADT from TCGA and mCRPC in SU2C[10] (Fig. 3A-C). AR-A was
167 elevated in Pri-PCa compared to adjacent benign tissue (N) but reduced in more aggressive Pri-PCa/ADT
168 samples, while the Stemness, in contrast, continually increased from N → Pri-PCa → Pri-PCa/ADT (Fig.
169 3B-C). Strikingly, mCRPC, despite markedly upregulating *AR* mRNA (Fig. 3A), showed the lowest AR-A
170 but highest Stemness (Fig. 3B-C), *indicating a shift from a positive correlation between AR-A and*
171 *Stemness in Pri-PCa to a negative association in mCRPC* (Fig. 3D).
172 By employing normalized RNAseq data from the PCa transcriptome atlas (Bolis 2021), which
173 included normal prostate specimens (n = 174), Pri-PCa (n = 714) and mCRPC (n = 335)[27], we tracked the
174 Stemness and AR-A across the PCa spectrum (Fig. 3E). AR-A increased from benign to Pri-PCa but
175 declined in Pri-PCa/ADT and continued to decrease in mCRPC, reaching its lowest in mCRPC-NE[28] as
176 supported by J-T test (Fig. 3E). In contrast, the Stemness exhibited a continually increasing trajectory
177 across the PCa spectrum encompassing Normal/Benign → treatment-naïve Pri-PCa → Pri-PCa/ADT →
178 (m)CRPC (P<0.0001, J-T Trend test; Fig. 3F; Supplementary Fig. S5A). Notably, the 3 subtypes of mCRPC,
179 i.e., AR-positive (ARPC), CRPC-NEPC and AR^-/NE^- double-negative PCa (DNPC) all showed higher
180 Stemness than Pri-PCa and also displayed increasing Stemness among the 3 subtypes (Supplementary
181 Fig. S5B). Unexpectedly, tumor-adjacent benign prostate tissues showed much higher Stemness than
182 normal prostate in the Genotype-Tissue Expression Project (GTEx)[29] (Fig. 3F; Supplementary Fig. S5A),
183 the majority of which were from cancer-free organ donors. This surprising finding suggests that the
184 transcriptomes of adjacent benign tissues have apparently skewed towards those of cancer samples,
185 consistent with previous observations that adjacent benign tissues represent an intermediate state
186 between healthy and tumor tissues[30]. Also of interest, the Cancer Cell Line Encyclopedia (CCLE)[31, 32] cell
187 lines including PCa cell lines, and PCa-derived PDX[33] and xenografts[34] exhibited the highest Stemness
188 (Fig. 3F; Supplementary Fig. S5A), supporting that cancer cell lines and xenografts are clonally derived
189 and highly enriched in cancer stem cells.
190 As in our early dissection of the relationship between AR-A and Stemness during spontaneous Pri-
191 PCa progression (Fig. 2F-G), analysis of the Bolis 2021 PCa transcriptome atlas[27] revealed a similar
192 change from a positive correlation between AR-A and Stemness in Pri-PCa (blue line; Pearson's r=0.32,
193 P<0.0001; Fig. 3G) to a negative correlation between the two in mCRPC (green line; Pearson's r=-0.15,
194 P=0.005; Fig. 3G). We further extended our Stemness and AR-A interrogation to include microarray-
195 derived transcriptomic datasets[35, 36], allowing us to access data from PCa cohorts generated before the
196 Next-generation sequencing (NGS) era. Analyzing the GRID database of over 82,000 prospectively
197 collected biopsy samples of localized PCa from clinical use of the Veracyte Decipher test[35], we
198 systematically quantified the Stemness across the NCCN Risk Groups and observed increasing Stemness

199 along the NCCN Risk trajectory (Fig. 3H). Likewise, in the Taylor dataset[36], we observed that AR-A was
200 the highest in Pri-PCa but significantly decreased in metastatic PCa (mPCa) (Fig. 3I) while the Stemness
201 increased progressively from benign to Pri-PCa and reached the highest levels in mPCa (Fig. 3J). Linear
202 regression analysis confirmed a gradual loss of positive correlation between AR-A and Stemness during
203 PCa progression, as illustrated by distinct regression lines for each stage (Fig. 3K-M).
204 Finally, we analyzed the dynamic changes of Stemness and AR in genetically engineered mouse
205 models (GEMMs) of PCa with increasing aggressiveness due to individual or combined deletion of 3 tumor
206 suppressor genes, *Pten*, *Rb1* and *Trp53*[37]. Briefly, *Pten*$^{-/-}$ single knockout (SKO) prostate tumors develop
207 around 9 weeks, and mice rarely develop metastasis with a median lifespan of 48 weeks. In contrast, the
208 *Pten*$^{-/-}$;*Rb1*$^{-/-}$ double knockout (DKO) mice develop highly metastatic PCa that shortens median survival to
209 ~38 weeks. When *Trp53* is further deleted in DKO background, the triple KO (TKO; *Pten*$^{-/-}$;*Rb1*$^{-/-}$;*Trp53*$^{-/-}$)
210 tumors are exclusively AR^{-} NEPC and castration-resistant *de novo* with high metastatic rate and lifespan
211 of ~16 weeks[37]. We found that the AR-A was the highest in SKO tumors but much reduced in aggressive
212 DKO and TKO tumors (Supplementary Fig. S5C). In contrast, Stemness was the lowest in SKO but
213 significantly increased in DKO and TKO (Supplementary Fig. S5D). Correlation analyses revealed a
214 positive correlation between AR-A and Stemness in SKO that turned to negative correlations in both DKO
215 and TKO tumors (Supplementary Fig. S5E-H).
216 The above results, collectively, indicate that *hormone therapy and metastatic progression further*
217 *drive marked increases in Stemness with concomitant decreases in pro-differentiation AR-A*.
218
219 **Stemness is prognostic of poor survival in PCa patients.**
220 We investigated global Stemness and its prognostic significance, and observed that high Stemness
221 consistently correlated with worse patient survival across various cohorts including the Spratt 2017[38]
222 (P=0.001, log-rank; Fig. 4A), Tosoian 2020[39] (P=0.014, log-rank; Fig. 4B), CHAARTED 2021[40] (P=0.006,
223 log-rank; Fig. 4C; P=0.149, log-rank; Supplementary Fig. S6A), and the mCRPC (SU2C 2019[41]; P=0.06,
224 log-rank; Supplementary Fig. S6B-C) as well as Taylor 2010[36] (P=0.028, log-rank; Supplementary Fig.
225 S6D-E). Notably, the CHAARTED cohorts displayed the highest mean Stemness compared to Tosoian
226 and Spratt cohorts, and the CHAARTED cohort showed the highest median Decipher Prostate Genomic
227 Classifier[38, 39, 40] among the three cohorts (Fig. 4D). Interestingly, like high Stemness, low AR-A was
228 correlated with poor patient survival in the Taylor dataset (P=0.040, log-rank; Supplementary Fig. S6F).
229
230 **Stemness-high PCa are associated with aggressive molecular subtypes and a 12-gene PCa-Stem**
231 **signature prognosticates poor patient survival.**
232 To identify key drivers of Stemness and explore differences between tumors with high versus low
233 Stemness, we stratified Pri-PCa (TCGA-PRAD) and mCRPC (SU2C 2019) samples separately based on
234 Stemness scores (Fig. 5A). Differential gene expression (DEG) analyses revealed significant differences

235 between the top 33% (Stemness-high) and the bottom 33% (Stemness-low) PCa samples in both
236 treatment-naïve Pri-PCa (Fig. 5B) and treatment-failed mCRPC (Fig. 5C), resulting in a 12-gene "**PCa-**
237 **Stem signature**" (Fig. 5D; Supplementary Table S2).

238 Gene set enrichment analysis (GSEA) was performed to delineate the molecular differences between
239 Stemness-low and Stemness-high PCa samples (Fig. 5E-F). GSEA revealed that Stemness-high PCa
240 samples were enriched in gene sets associated with embryonic stem cells (ESC), as well as aggressive
241 cancer phenotypes, such as undifferentiated cancer and metastasis, in both Pri-PCa and mCRPC (Fig.
242 5F). In contrast, Stemness-low PCa samples were enriched in gene signatures linked to lower
243 aggressiveness and inflammatory pathways (Fig. 5E). Additionally, hallmark pathways such as E2F targets,
244 MYC targets, mTORC1 signaling, and DNA repair were upregulated in Stemness-high PCa (Fig. 5F), while
245 TGF-β signaling, TNF-α signaling, and IFN-γ responses were prominent in Stemness-low PCa (Fig. 5E).

246 The aggressive PAM50-LumB molecular subtype[42, 43, 44] was significantly more prevalent in
247 Stemness-high PCa, accounting for 74% in Pri-PCa (compared to 15% in Stemness-low PCa; Fig. 5G)
248 and 43% in mCRPC (compared to 4% in Stemness-low PCa; Fig. 5H). The PCS1 subtype[45, 46], known for
249 its association with ADT resistance and the highest risk of progression to advanced disease in comparison
250 with PCS2 or PCS3, was predominantly enriched in both Stemness-high Pri-PCa and mCRPC (Fig. 5I-L).
251 Notably, the PAM50-Basal subtype[42, 43] increased in Stemness-high mCRPC but not in Pri-PCa (Fig. 5G-
252 H), aligning with the characteristics of mCRPC, which involves lineage plasticity and acquisition of basal,
253 mesenchymal, neural and stem-like phenotypes when developing ARPI resistance[7, 44, 47]. Consequently,
254 Stemness-high samples remained largely AR-dependent[48] in Pri-PCa (Fig. 5M) but transitioned to AR-
255 independent NE subtype[44] in mCRPC (Fig. 5N). Stemness-high PCa was also characterized by high
256 proliferation as evidenced by their enrichment in a 31-gene cell-cycle progression signature[44] (Fig. 5O-P).
257 Finally, we examined the association between Stemness and a signature of lineage plasticity risk after
258 Enza treatment for mCRPC[12] and found that Stemness-high tumors may be at risk for this virulent form of
259 treatment resistance (Fig. 5Q-R).

260 To further assess the clinical relevance of Stemness, we analyzed the prognostic impact of our newly
261 developed 12-gene PCa-Stem signature (Fig. 5D). We observed that higher PCa-Stem signature
262 correlated with worse patient survival in both Pri-PCa (P<0.0001, log-rank; Fig. 5S-T) and mCRPC
263 (P<0.0001, log-rank; Fig. 5U-V) patients. Multivariate analysis, adjusted for clinicopathologic parameters
264 such as age, GS and stage, showed that patients with high PCa-Stem signature had significantly worse
265 independent prognosis compared to those with low PCa-Stem signature. This was demonstrated by worse
266 progression-free survival (PFS) in Pri-PCa (multivariable-adjusted HR=1.636 (1.014 – 2.64), P=0.0438;
267 Fig. 5T) and overall survival (OS) in mCRPC (multivariable-adjusted HR=4.712 (2.011 – 11.04), P<0.001;
268 Fig. 5V), respectively. Furthermore, the PCa-Stem signature steadily and continually increased across the
269 PCa evolutionary spectrum and correlated with PCa disease progression scores as supported by trajectory
270 inference analysis of the Bolis PCa transcriptome atlas[27] (Pearson's r=0.72; Supplementary Fig. S7A-B).

271 Strikingly, gene expression analysis revealed that 11 of the 12 genes (except *KLK12*) in the PCa-Stem
272 signature significantly correlated with the PCa disease progression (Supplementary Fig. S7C). In contrast,
273 among the genes commonly downregulated in Stemness-high PCa samples in both Pri-PCa and mCRPC
274 (Supplementary Table S3), some (e.g., *PTGDS*, *SPARCL1*, *CLU*, *GJA1* and *S100A4*) were involved in
275 regulating prostate-specific glandular structures and luminal functions while others (e.g., *FBLN1*, *SFRP1*,
276 *IGFBP6*, *GAS1* and *TIMP2*) played general roles in epithelial differentiation (Supplementary Fig. S7D).
277 Overall, these findings indicate that *PCa with high Stemness exhibit greater aggressiveness, a higher*
278 *likelihood of developing lineage plasticity and therapy resistance, and poor survival outcomes*.
279
280 **Stemness-high PCa have high tumor mutation burden (TMB) and unique genomic features.**
281 We determined the potential differences in genomic features between Stemness-high vs. Stemness-low
282 PCa and found that mCRPC had a higher fraction of altered genome (Fig. 6A) and higher TMB (Fig. 6B)
283 than Pri-PCa. In both Pri-PCa and mCRPC, Stemness-high PCa displayed a higher fraction of altered
284 genome (Fig. 6A) and TMB (Fig. 6B) than Stemness-low PCa although there was no difference in patient
285 ages (Fig. 6C). In Pri-PCa, Stemness-high samples had a higher prevalence of *PTEN* deletion (DEL),
286 *SPOP* and *FOXA1* mutations (MUT) and *MYC* amplification (AMP) whereas in mCRPC, Stemness-high
287 PCa had more prevalent *RB1* DEL and *AR* MUT (Fig. 6D-F).
288 Globally, both Pri-PCa and mCRPC exhibited mutations in more than a dozen genes although most
289 of these alterations were <10% (Supplementary Fig. S8A; green symbols), consistent with reports that
290 PCa is genomically heterogeneous with a broad spectrum of genomic alternations of low penetrance[49, 50].
291 On the other hand, homozygous deletion (HOMDEL) events, particularly, loss of *PTEN* and *RB1*, occurred
292 frequently in both Pri-PCa and mCRPC (Supplementary Fig. S8A; blue symbols) whereas AMP events in
293 oncogenes such as *MYC* were more prevalent in mCRPC (Supplementary Fig. S8A; red symbols).
294 Nevertheless, *PTEN* and *RB1* DEL represented among the most prevalent alterations in early-stage (GS6)
295 PCa (Supplementary Fig. S8B-C). Analysis of genetic alterations across the spectrum of PCa progression
296 revealed that among the 3 tumor suppressors (*RB1, PTEN* and *TP53*), while homozygous *RB1* DEL
297 remained relatively constant at 13%, 6%, 10% and 10% in low-grade (GS6), high-grade (GS9/10), treated
298 Pri-PCa and mCRPC, respectively, *PTEN* HOMDEL (9%, 23%, 30% and 26%) and *TP53* MUT (0%, 21%,
299 27% and 37%) continued to increase along this progression (Supplementary Fig. S8B-C). Among the 3
300 oncogenic events analyzed, while high levels of *TMPRSS2* fusions (~40%) remained unchanged from low-
301 grade to high-grade Pri-PCa to mCRPC, *MYC* (2%, 12%, 19% and 24%) and *AR* (0%, 1%, 6% and 49%)
302 AMP continued to increase along the progression trajectory (Supplementary Fig. S8B-C). In fact, prevalent
303 *AR* MUT (11%) were observed only in the most aggressive and Stemness-highest mCRPC
304 (Supplementary Fig. S8B-C), suggesting potentially high noncanonical AR-A in mCRPC. Analyzing these
305 major genomic alterations in association with PCa Stemness, we observed that *RB1* DEL, *FOXA1*
306 (together with *SPOP*, *IDH1*, and *CHD1*) MUT, and especially *MYC* AMP were significantly associated with

307 increased Stemness in Pri-PCa (Supplementary Fig. S8D). In mCRPC, only *RB1* DEL exhibited a
308 statistically significant association with higher Stemness (Supplementary Fig. S8E).
309
310 **MYC further drives Stemness during spontaneous PCa progression.**
311 *AR* AMP and MUT are exclusively treatment-induced as there were virtually no *AR* genomic alterations in
312 treatment-naïve Pri-PCa (Supplementary Fig. S8B-C). We showed that early during PCa development
313 increased AR-A may drive elevated Stemness (Fig. 1D-F); however, treatment-naïve Pri-PCa displayed
314 continually increasing Stemness but decreasing AR-A (Fig. 2). What could be driving persistently high
315 Stemness during Pri-PCa progression with decreasing AR-A and in the absence of *AR* genomic alterations?
316 We found that Stemness-high Pri-PCa, compared to Stemness-low Pri-PCa, were enriched in MSigDB
317 Hallmark MYC_TARGETS (MYC_Targets_V1 and MYC_Targets_V2; Fig. 5F) and had more prevalent
318 *MYC* AMP (Fig. 6D and 6F). High-grade (GS9/10) Pri-PCa also had more *MYC* AMP events than low-
319 grade (GS6) Pri-PCa (12% vs. 2%; P=0.006, χ^2 test; Supplementary Fig. S8C). Importantly, *MYC* AMP
320 was most prominently associated with increased Stemness in Pri-PCa (Supplementary Fig. S8D). These
321 observations led us to hypothesize that MYC may represent a critical Stemness driver during spontaneous
322 Pri-PCa progression (in absence of therapeutic pressure). To test this hypothesis, we quantified MYC
323 signaling activity[51] (MYC-sig; See Methods and Supplementary Table S2 for gene signature information)
324 across the PCa progression spectrum. We observed that: 1) both *MYC* mRNA and MYC-sig increased in
325 Pri-PCa compared to matched benign samples (Fig. 7A-B); 2) MYC-sig continued to go up during Pri-PCa
326 progression (Fig. 7C); 3) unlike nADT-induced concomitant decline in both AR-A and Stemness (Fig. 1D-
327 F; Supplementary Fig. S4), nADT showed no discernible effect on MYC-sig (Supplementary Fig. S9A-D);
328 and 4) MYC-sig continued to increase across the disease spectrum with mCRPC exhibiting the highest
329 MYC activity (Fig. 7D-E) and with MYC-sig positively correlated with the Stemness (Fig. 7F-H).
330 *These results, together, support MYC as a Stemness driver during PCa progression*.

331 **DISCUSSION**

332 The current project was undertaken to quantitatively co-analyze the global changes of and the
333 interrelationship between cancer stemness and pro-differentiation AR signaling activity during PCa
334 evolution. By employing gene expression-based general Stemness and AR-A signature scores and
335 through developing a new 12-gene PCa-Stem signature, we show that while the differentiation-regulating
336 AR-A steadily declines in the PCa continuum, pervasively increasing Stemness quantitatively measures
337 PCa aggressiveness, plasticity and progression, and represents a poor prognosticator for patient outcomes.
338 We report that Stemness-high PCa possess unique genomic features with high TMBs and are associated
339 with aggressive molecular subtypes. We further present evidence that elevated Stemness in early PCa
340 might be driven by increased AR-A but increased MYC-sig activity and other genomic alterations likely
341 propagate the exponentially increased Stemness in mCRPC where AR-A is suppressed.
342
343 Early studies reported that a cohort of AR-regulated genes declines in high-grade versus low-grade Pri-
344 PCa[52, 53] and that loss of AR expression or inhibition of AR-A promotes a stem-like phenotype[8, 34, 54, 55].
345 However, the global pro-differentiation AR-A and cancer stemness have not been systematically and
346 quantitatively assessed and co-analyzed in PCa, and it's unclear whether PCa progression is accompanied
347 by increased stemness as in some other cancers such as glioblastoma and breast cancer [6]. Our analysis
348 demonstrates that PCa progression is accompanied by a continual increase in Stemness (score) but loss
349 of canonical AR-A, with the two inversely correlated with each other (Supplementary Fig. S10). Importantly,
350 the Stemness tracks treatment-induced plasticity and PCa aggressiveness, and both high global Stemness
351 and high PCa-Stem signature prognosticate poor patient survival. To our knowledge, this is the first
352 comprehensive study to simultaneously quantify the oncogenic stemness and pro-differentiation AR-A
353 across the PCa continuum.
354
355 The normal prostatic acini and ducts are lined by AR^+ secretory luminal cells and AR^- basal cells together
356 with rare neuroendocrine cells. We find that the NHP luminal cells have higher AR-A compared to basal
357 cells, confirming AR-A as a metric for quantifying canonical AR activity and prostatic epithelial
358 differentiation. On the other hand, basal cells have higher Stemness, consistent with earlier findings from
359 our lab[19] and others[20, 21, 22, 56] showing the basal cell compartment harbors stem cells. Oncogenic
360 transformation is known to confer stem-like features in the initiated cells. Indeed, compared to adjacent
361 benign tissue, Pri-PCa exhibit elevated Stemness, which is associated with and likely driven by increased
362 AR-A. Loss of *PTEN* and *RB1* (9% and 13%, respectively, in GS6 tumors) could also potentially contribute
363 to increased Stemness in early prostate tumors. Interestingly, tumor-adjacent benign tissues display higher
364 Stemness than normal prostate, suggesting that these benign tissues are not normal.

365 In treatment-naïve Pri-PCa, tumor progression is accompanied by decreasing AR-A but persistently high
366 Stemness (Supplementary Fig. S10). The decreasing AR-A is driven by progression-related loss of
367 differentiation while increasing Stemness is likely driven by *MYC* amplification and increased MYC activity
368 with contributions from other oncogenic evens such as loss of *PTEN* and *RB1*. Long-term ADT/ARPI
369 treatment, as expected, further attenuates AR-A but substantially upregulates the Stemness such that
370 mCRPC have the highest Stemness, which is probably driven by continually increasing genomic alterations
371 such as *MYC* amplification and loss of tumor suppressors. Notably, as *AR* alterations (AMP/MUT) are
372 exclusively induced by ARPIs, noncanonical AR-A (i.e., castration-resistant AR activity) likely make
373 significant contributions to the increased Stemness in mCRPC.
374
375 What biological correlates does our Stemness metric measure? *First*, it measures transcriptional features
376 and relative abundance of stem cells and CSCs. Therefore, the NHP basal/stem cells display higher
377 Stemness than luminal cells (consistent with literature[19, 20, 21, 22]); ARPI treatment, while shutting down AR
378 signaling, enriches CSCs[7, 34, 54, 55] and upregulates Stemness (this study); and PCa cell lines, xenografts
379 and PDX, known to be clonally derived from cancer stem/progenitor cells, demonstrate the highest
380 Stemness. *Second*, it measures cellular and lineage plasticity induced by treatment and genetic alterations.
381 Thus, mCRPC, which harbor more abundant treatment-reprogrammed $AR^{-/lo}$ cells and PCa cells with stem-
382 like features or in an AR-indifferent state[8, 12, 13, 14, 16, 33, 47, 48], manifests the highest Stemness. Our analysis
383 further substantiates the aggressive nature of ($AR^{-/lo}$) CRPC-NEPC and DNPC compared to ARPC, as
384 evidenced by their elevated PCa-Stem signature scores. This suggests a shift in the phenotypic landscape
385 of mCRPC towards more stem-like and aggressive forms, particularly under the pressure of advanced
386 therapies. Likewise, aggressive DKO and TKO murine prostate tumors have undergone lineage
387 transformation and also exhibit higher Stemness than indolent SKO tumors. *Third*, the Stemness metric
388 likely reports the high proliferative status of advanced PCa and mCRPC, as Stemness-high tumors in both
389 Pri-PCa and mCRPC are enriched in “Cell-cycle progression” signature and most genes in the 12-gene
390 PCa-Stem Signature are involved in mitosis and cell-cycle progression. *Finally*, the Stemness score
391 measures PCa aggressiveness as high Stemness correlates not only with more advanced and aggressive
392 stages of PCa but also with aggressive PAM50-LumB and PCS1 molecular subtypes.
393
394 Of clinical significance, both the 12-gene PCa-Stem signature and the global Stemness score correlate
395 with poor patient survival, suggesting the possibility of developing the Stemness metric into a predictive
396 biomarker to distinguish aggressive from indolent primary tumors and a prognostic indicator of unfavorable
397 clinical outcomes in mCRPC patients. Notably, 11 of the 12 genes (except *KLK12*) in the newly developed
398 PCa-Stem signature are significantly correlated with PCa progression (Supplementary Fig. S7C)
399 implicating their individual contributions to the increased Stemness in advanced Pri-PCa and mCRPC.
400 Analysis using data from The Human Protein Atlas (www.proteinatlas.org) reveals that these 11 genes are

401 also recognized as unfavorable prognostic markers in PCa and several other cancers (Liu X and Tang,
402 unpublished), raising the potential utility of the PCa-Stem signature as a prognostic marker not only for
403 PCa but also for other malignancies. Coupled with earlier studies linking increased Stemness with
404 aggressive breast and brain cancer subtypes (6), our findings herein underscore the increased Stemness
405 as a 'universal' and fundamental characteristic of cancer progression and aggressiveness.
406
407 We recognize that the Stemness algorithm utilized in our studies was not developed specifically for PCa
408 and therefore, its sensitivity to distinguish subtle intra-group differences remains to be fully validated. The
409 bulk RNA-seq data used to derive Stemness and AR-A was not from pure epithelial cancer cells, a
410 technical issue that can be potentially amended by scRNA-seq analysis and other Stemness pipelines
411 such as the CytoTRACE[57, 58] and by using cancer-specific genomic features derived, for example, from
412 cell-free DNA[59]. Finally, it will be important to determine whether and how noncanonical (castration-
413 associated) AR signaling (driven by *AR* AMP/MUT) may contribute to the highest Stemness in mCRPC.
414
415 In conclusion, we have developed transcriptome-based gene signature scores to assess pro-differentiation
416 AR activity (AR-A), MYC activity (MYC-sig) and oncogenic stem-cell features (general Stemness score
417 and the 12-gene PCa-Stem signature). These scores enable us to globally profile differentiation and
418 aggressiveness status across the PCa progression spectrum. This work advances our understanding of
419 dynamic evolution of AR-A and cancer stemness during PCa progression and therapy resistance, and the
420 signature scores reported herein have the potential to serve as clinical classifiers and aid in the
421 identification of patients who may benefit from stemness-targeting therapies.

422 **METHODS**

423 **PCa clinical datasets and data collection**

424 In this study, we utilized a total of 26 published and in-house prostate cancer (PCa) related datasets,
425 including various cohorts encompassing the evolutionary spectrum of PCa (Supplementary Fig. S1A-B):
426 normal prostate, tumor-adjacent benign tissue, treatment-naïve primary PCa (Pri-PCa) with increasing GS,
427 PCa treated with neo-adjuvant ADT (nADT) or long-term ADT, metastatic castration-resistant PCa
428 (mCRPC), and PCa cell lines, PCa patient-derived xenografts (PDX) and xenografts. Clinical information,
429 genomic data and gene expression profiling data were downloaded and detailed information on each
430 dataset is listed in Supplementary Table S1. Dataset descriptions include dataset source references,
431 PubMed IDs (PMIDs; RRID:SCR_004846), DOI links, sample type and source (e.g., normal prostate tissue,
432 adjacent benign prostate tissue or primary culture from PCa patient, primary or metastatic prostate tumor,
433 xenografts, cell lines), sample sizes, data types used in the current study (clinicopathologic data, RNAseq,
434 microarray, whole exome sequencing [WES]), and public data access portals.
435
436 Data Access and Repository Information: Data for this study were retrieved from the following public
437 repositories and databases (persistent identifiers where applicable):
438 1. GTEx Portal (RRID:SCR_013042; https://gtexportal.org/)
439 2. Gene Expression Omnibus (GEO; RRID:SCR_005012; https://www.ncbi.nlm.nih.gov/geo/)
440 3. cBioPortal for Cancer Genomics (RRID:SCR_014555; https://www.cbioportal.org/)
441 4. Zenodo Repository (RRID:SCR_004129; https://zenodo.org/)
442 5. Decipher GRID Database (RRID:SCR_006552; ClinicalTrials.gov identifier: NCT02609269)
443 6. European Genome-phenome Archive (EGA; RRID:SCR_004944; https://ega-archive.org/)
444 7. European Nucleotide Archive (ENA; RRID:SCR_006515; https://www.ebi.ac.uk/ena/browser/home)
445 8. UCSC Xena Functional Genomics Portal (RRID:SCR_018938; https://xenabrowser.net/)
446 Accession numbers and portal links for the 26 datasets described below are provided in Supplementary Table S1.
447
448 The 26 datasets are briefly described below:
449 1) **GTEx 2013** (PMID: 23715323)[29]: The Genotype-Tissue Expression (GTEx) Project repository collected
450 high-throughput and clinical data of normal tissue from many organs. RNAseq data of 245 normal
451 prostate tissue samples was downloaded from the GTEx portal (RRID:SCR_013042; ref. 29; DOI:
452 10.1038/ng.2653; https://www.gtexportal.org/, version: v8).
453 2) **Smith 2015** (PMID: 26460041)[20]: RNAseq data of 5 prostate basal cell samples ($Trop2^{+}CD49f^{hi}$) and
454 corresponding 5 luminal cell samples ($Trop2^{+}CD49f^{lo}$) FACS-purified from benign human prostate
455 tissue in 5 PCa patients (n=5) was retrieved from the GEO database GSE82071 (ref. 20; DOI:
456 10.1073/pnas.1518007112).

457 3) **Liu 2016** (PMID: 27926864)[56]: RNAseq data of 3 FACS-purified human prostate basal cell samples
458 ($CD45^-EpCAM^+CD49f^{hi}CD38^{lo}$) with corresponding luminal ($CD45^-EpCAM^+CD49f^{lo}CD38^{hi}$) and luminal
459 progenitor ($CD45^-EpCAM^+CD49f^{lo}CD38^{lo}$) cell populations purified from the benign prostate tissues of
460 3 PCa patients (n=3) was retrieved from the supplementary data from Liu *et al.*, 2016 (ref. 56). The
461 microarray-based transcriptomic profiles of the same samples were retrieved from the GEO database
462 GSE89050 (ref. 56; DOI: 10.1016/j.celrep.2016.11.010).
463 4) **Zhang 2016** (PMID: 26924072)[19]: RNAseq data of 3 human prostate basal cell ($Trop2^+CD49f^{hi}$) with the
464 corresponding 3 luminal cell ($Trop2^+CD49f^{lo}$) samples FACS-purified from benign prostate tissues of 3
465 PCa patients (n=3) was retrieved from the GEO database GSE67070 (ref. 19; DOI:
466 10.1038/ncomms10798).
467 5) **TCGA PRAD 2015** and **Pan-Cancer Atlas 2018**: The Cancer Genome Atlas (TCGA)
468 (https://www.cancer.gov/tcga) repository collected high-throughput molecular and clinical data from
469 primary cancer and matched normal/benign samples spanning 33 human cancer types, including
470 prostate adenocarcinoma (PRAD). For each cancer type, TCGA published an initial "marker papers"
471 summarizing analyses performed. Supplemental and associated data files supporting these "marker
472 papers" are available through the NCI Genomic Data Commons (GDC) website
473 (https://gdc.cancer.gov/about-data/publications). For prostate cancer, **TCGA PRAD 2015** (PMID:
474 26544944; ref. 18; DOI: 10.1016/j.cell.2015.10.025) is the marker paper on PCa published in 2015,
475 which includes the dataset of 333 primary prostate adenocarcinomas (281 treatment-naïve Pri-PCa,
476 49 PCa with post-surgery adjuvant ADT, and 52 matched normal/benign prostate tissue). Genomic
477 data were obtained from **cBioPortal for Cancer Genomics** (RRID:SCR_014555;
478 https://www.cbioportal.org), specifically the TCGA-PRAD Firehose Legacy study
479 (https://www.cbioportal.org/study/summary?id=prad_tcga). RNAseq expression data was obtained
480 from Zhang *et al.*, 2020 (PMID: 32350277; ref. 16; DOI: 10.1038/s41467-020-15815-7).
481 The expanded **TCGA PRAD 2018 (Pan-Cancer Altas)** cohort includes 494 patients with Pri-PCa
482 (422 treatment-naïve Pri-PCa, 70 PCa with post-surgery adjuvant hormone treatment, 2 PCa with
483 chemotherapy) and 52 matched adjacent normal/benign prostate tissue. Clinicopathologic features
484 (age, Gleason scores, PSA levels, tumor stages) and genomic alterations data (mutation frequency,
485 copy number alterations [CNAs], structural variants [SVs], tumor mutation burden [TMB], fraction
486 genome altered) were retrieved from cBioPortal for Cancer Genomics PRAD PanCancer Atlas study
487 (https://www.cbioportal.org/study/summary?id=prad_tcga_pan_can_atlas_2018) and from the Pan-
488 Cancer Atlas companion site (welcome to the Pan-Cancer Atlas webpage: https://www.cell.com/pb-
489 assets/consortium/pancanceratlas/pancani3/index.html). Survival data were obtained from Liu *et al.*,
490 2018[60] (PMID: 29625055; DOI: 10.1016/j.cell.2018.02.052). Normalized RNAseq data were
491 downloaded via NCI GDC hub at UCSC Xena Functional Genomics Portal (https://gdc.xenahubs.net,
492 version 2019-07-20; DOI: 10.1038/s41587-020-0546-8).

493 6) **Rajan 2014** (PMID: 24054872)[25]: Clinicopathologic (Gleason scores) and RNAseq data of 7 matched
494 pre- and post-nADT PCa samples were obtained, respectively, from Table 1 in Rajan *et al*., 2014 (ref.
495 25; DOI: 10.1016/j.eururo.2013.08.011) and the GEO database GSE48403.
496 7) **Sharma 2018** (PMID: 30314329)[26]: Clinicopathologic (Gleason scores) and RNAseq data of 7 matched
497 pre- and post-nADT PCa samples from the responder group (also defined as "Low Impact Group" in
498 the source reference) was obtained, respectively, from supplementary Table 1 in Sharma *et al*., 2018
499 (ref. 26; DOI: 10.3390/cancers10100379) and the GEO database GSE111177.
500 8) **Long 2020** (PMID: 32951005; DOI: 10.1016/j.eururo.2013.08.011)[24]: RNAseq data of 6 matched pre-
501 and post-nADT PCa samples was obtained from the GEO database GSE82071. Additionally, RNAseq
502 data from 10 locally advanced PCa samples along with their paired adjacent benign prostate tissues
503 were obtained from the GEO database GSE82071.
504 9) **Nastiuk (RPCI) 2020** (submitted)[61]: Clinicopathologic data (Gleason scores) and RNAseq data of 43
505 Pri-PCa samples from post-nADT PCa patients and 43 tumor samples from age-, stage-, clinically-
506 matched PCa patients without nADT was obtained from Jamroze *et al*., 2024 (work led by Drs. K.
507 Nastiuk and G. Chatta at the Roswell Park Comprehensive Cancer Center). RNAseq data and
508 clinicopathologic information from the Nastiuk 2020 cohort (unpublished) were provided in-house by
509 Dr. K. Nastiuk and are available from the corresponding author upon reasonable request.
510 10) **Gerhauser 2018** (PMID: 30537516; DOI: 10.1016/j.ccell.2018.10.016)[62]: RNAseq data of 118 primary
511 tumor samples and 9 adjacent benign prostate tissue from early-onset PCa patients was obtained from
512 the European Genome-Phenome Archive (EGA) (https://ega-archive.org), accession number
513 EGAS00001002923.
514 11) **Wyatt 2014** (PMID: 25155515; DOI: 10.1186/s13059-014-0426-y)[23]: Clinicopathologic (Gleason
515 scores) and RNAseq data of 12 primary PCa samples from treatment-naïve PCa patients and 12
516 adjacent benign prostate tissue were obtained from the European Nucleotide Archive (ENA)
517 (https://www.ebi.ac.uk/ena/browser/home), accession number PRJEB6530.
518 12) **Spratt 2017** (PMID: 28358655; DOI: 10.1200/JCO.2016.70.2811)[38]: Transcriptomic profiles
519 (Microarray) and clinicopathologic data of 855 radical prostatectomy specimens from a multi-
520 institutional study of intermediate- and high-risk localized PCa patients were obtained from Veracyte
521 GRID (https://decipherbio.com/grid/).
522 13) **Tosoian 2020** (PMID: 32231245; DOI: 10.1038/s41391-020-0226-2)[39]: Transcriptomic profiles
523 (Microarray) and clinicopathologic data of 405 radical prostatectomy and biopsy specimens from high-
524 risk localized PCa patients were obtained from Veracyte GRID (https://decipherbio.com/grid/).
525 14) **CHAARTED correlatives 2021** (PMID: 34129855; DOI: 10.1016/j.annonc.2021.06.003)[40]:
526 Transcriptomic profiles (Microarray) and clinicopathologic data of 160 biopsy specimens from a Phase
527 3 trial of metastatic hormone-sensitive PCa patients were obtained from the NCTN Data Archive
528 (https://nctn-data-archive.nci.nih.gov), accession number **NCT00309985-D14**.

529 15) **Decipher GRID Biopsy** (PMID: 37060201; DOI: 10.1002/cncr.34790)[35]: Transcriptomic profiles from
530 82,470 prospectively collected prostate biopsy samples were retrieved from the Decipher GRID
531 database (RRID: SCR_006552; https://decipherbio.com/grid; ClinicalTrials.gov identifier:
532 **NCT02609269;** https://clinicaltrials.gov/ct2/show/NCT02609269). Patient data were de-identified from
533 clinical use of the Decipher prostate genomic classifier in accordance with the Safe Harbor method
534 described in the HIPAA Privacy Rule 45 CFR 164.514(b) and (c) (Veracyte, San Diego, CA). The
535 samples, comprising a large cohort of localized prostate cancer (PCa), were utilized to compare the
536 distribution of Stemness Index values across National Comprehensive Cancer Network (NCCN) risk
537 groups.

538 Clinicopathologic Breakdown and Risk Group Analysis:

539 Detailed clinicopathologic review revealed that the majority of the cohort presents with low-grade
540 localized PCa. The TNM staging breakdown includes:

541 - **T1 stage:** Approximately 50% of samples, indicating early-stage cancer localized within
542 the prostate.
543 - **T2 stage:** Approximately 8%, representing cancer confined within the prostate but more
544 extensive than T1.
545 - **T3 and T4 stages:** Less than 1%, suggesting advanced local spread.
546 - **N0:** Approximately 98%, indicating no regional lymph node involvement.
547 - **N1:** Approximately 2%, suggesting regional lymph node involvement.

548 The Decipher GRID database (RRID:SCR_006552) categorizes patients into NCCN risk groups
549 based on TNM stage, PSA level, and Gleason score:

550 - **Very Low and Low Risk:** T1–T2a, N0, M0, PSA <10 ng/mL, and Gleason score ≤6; often
551 managed with active surveillance or less aggressive treatment.
552 - **Intermediate Risk – Favorable:** Typically T2b–T2c, N0, M0, PSA 10–20 ng/mL, and
553 Gleason score 7; managed with less aggressive treatment but closer monitoring.
554 - **Intermediate Risk – Unfavorable:** Similar clinical features to favorable but with higher
555 disease burden or adverse factors requiring careful monitoring.
556 - **High Risk:** Usually involves T3a, N0, M0, PSA >20 ng/mL, or Gleason score 8–10; often
557 managed aggressively with surgery, radiation, and/or hormonal therapy.
558 - **Very High Risk:** Typically includes T3b–T4, any N, M0, and high Gleason scores or PSA
559 levels (PSA >20 ng/mL); patients are at significant risk for metastatic progression and are treated
560 aggressively, often with multimodal therapies.

561

562 Observations on Disease Severity and Treatment Naïvety:

563 Analysis of the cohort indicates that only approximately 13% of cases fall into the High and Very High
564 risk categories (8,376 + 2,399 = 10,775 samples), suggesting that the majority (approximately 87%)

565 are below Intermediate Risk (≤GS7). This distribution implies that most patients were treatment-naïve
566 and likely androgen deprivation therapy (ADT)-free due to less aggressive disease status.
567 16) **Bolis 2021** (PMID: 34857732; DOI: 10.1038/s41467-021-26840-5)[27]: RNAseq and clinicopathologic
568 data of 1,223 clinical samples from an integrated cohort consisting of normal prostate specimens
569 (n = 174), Pri-PCa (n = 714) and mCRPC (n = 335) was obtained from the Zenodo repository (Record
570 ID: 5546618; https://zenodo.org/records/5546618). This resource of Prostate Cancer Transcriptome
571 Atlas (https://prostatecanceratlas.org) was built and integrated from the following studies/datasets: (1)
572 Genotype-Tissue Expression Database (GTEx; PMID: 23715323; ref. 29); (2) The Cancer Genome
573 Atlas (TCGA, TCGA-PRAD; PMID: 26544944; ref. 18); (3) Atlas of RNA-sequencing profiles of normal
574 human tissues[63] (GSE120795; PMID: 31015567; ref. 63); (4) Integrative epigenetic taxonomy of
575 PNPCa[64] (GSE120741; PMID: 30464211; ref. 64); (5) Prognostic markers in locally advanced lymph
576 node-negative prostate cancer (PRJNA477449); (6) The long noncoding RNA landscape of NEPC and
577 its clinical implications[65] (PRJEB21092; PMID: 29757368; ref. 65); (7) Integrative clinical sequencing
578 analysis of metastatic CRPC reveals a high frequency of clinical actionability (PRJNA283922; dbGaP:
579 phs000915; PMID: 26000489; ref. 10); (8) CSER—exploring precision cancer medicine for sarcoma
580 and rare cancers [66](PRJNA223419; dbGaP: phs000673; PMID: 28783718; ref. 66); (9) Molecular basis
581 of NEPC (Beltran 2016; PRJNA282856; dbGaP: phs000909; PMID: 26855148; ref. 28); (10)
582 Heterogeneity of androgen receptor splice variant-7 (AR-V7) protein expression and response to
583 therapy in CRPC[67] (GSE118435; PMID: 30334814; ref. 67); (11) RNAseq of human PCa cell lines and
584 mCRPC tumor[68, 69, 70] (GSE14750; PMIDs: 32460015; ref. 68; 33658518; ref. 69; 34244513; ref. 70 |
585 GSE171729; PMID: 34244513; ref. 70); and (12) Molecular profiling stratifies diverse phenotypes of
586 treatment-refractory metastatic CRPC (PRJNA520923; GEO: GSE126078; PMID: 31361600; ref. 33).
587 17) **Taylor 2010** (PMID: 20579941; DOI: 10.1016/j.ccr.2010.05.026)[36]: Transcriptomic profiles (Microarray)
588 and clinicopathologic (recurrence-free survival) data of 29 adjacent benign prostate tissue, 131 Pri-
589 PCa, and 19 mPCa were obtained from the GEO database (GSE21034) and the cBioPortal for Cancer
590 Genomics PRAD MSKCC 2010 study (https://www.cbioportal.org/study/summary?id=prad_mskcc).
591 18) **SU2C 2015** (PMID: 26000489; DOI: 10.1016/j.cell.2015.05.001)[10]: Clinical and genomic data of 150
592 mCRPC samples were obtained from the cBioPortal for Cancer Genomics PRAD SU2C 2015 study
593 (https://www.cbioportal.org/study/summary?id=prad_su2c_2015). RNAseq data of 98 mCRPC
594 samples was retrieved from Zhang *et al.*, 2020[16] (PMID: 32350277; DOI: 10.1038/s41467-020-15815-
595 7; ref.16).
596 19) **SU2C 2019** (PMID: 31061129; DOI: 10.1073/pnas.1902651116)[41]: This dataset includes
597 clinicopathologic and genomic data for 444 mCRPC samples. RNAseq data of 266 mCRPC samples
598 (prepared by using poly(A) enrichment for RNAseq library construction) were obtained from the
599 cBioPortal for Cancer Genomics PRAD SU2C 2019 study
600 (https://www.cbioportal.org/study/summary?id=prad_su2c_2019). In parallel with TCGA-PRAD,

601 clinicopathologic features (age, Gleason scores, PSA levels), genomic alterations (mutation frequency,
602 CNAs, SVs, TMB, fraction genome altered), and patient outcome data (overall survival) were also
603 retrieved from cBioPortal (RRID:SCR_014555). These datasets were used for comparative analysis
604 between Stemness-high and Stemness-low groups, and to explore genomic drivers and clinical
605 associations as described in the Methods.

606 20) **Labrecque 2019** (PMID: 31361600; DOI: 10.1172/JCI128212)[33]: RNAseq data of 98 mCRPC samples
607 and 39 PDX-LuCaP was obtained from the GEO database GSE126078.

608 21) **Alumkal 2020** (PMID: 32424106; DOI: 10.1073/pnas.1922207117)[13]: RNAseq data of 25 mCRPC
609 samples before treatment with enzalutamide (ENZA) was obtained from Supplementary dataset S01
610 of Alumkal *et al.*, 2020 (ref. 13).

611 22) **Westbrook 2022** (PMID: 36109521; DOI: 10.1038/s41467-022-32701-6)[12]: RNAseq data of 42
612 mCRPC samples consisting of 21 matched pre/post Enzalutamide treatment samples was retrieved
613 from Westbrook *et al.*, 2022 (ref. 12).

614 23) **Beltran 2016** (PMID: 26855148; DOI: 10.1038/nm.4045)[28]: RNAseq data of mCRPC samples,
615 including 34 castration-resistant adenocarcinoma (mCRPC-Adeno) and 15 neuroendocrine histologies
616 (mCRPC-NEPC) samples, was obtained from cBioPortal for the Cancer Genomics
617 (https://www.cbioportal.org/study/summary?id=nepc_wcm_2016).

618 24) **Goodrich 2017** (PMID: 28059767; DOI: 10.1126/science.aah4199)[37]: RNAseq data of murine prostate
619 tumors from genetically engineering mouse models (GEMMs) of PCa of different genotypes, including
620 4 SKO (single knockout: PBCre4:*Pten*$^{f/f}$), 13 DKO (double knockout PBCre4:*Pten*$^{f/f}$*:Rb1*$^{f/f}$), and 6 TKO
621 (PBCre4:*Pten*$^{f/f}$*:Rb1*$^{f/f}$*:Trp53*$^{f/f}$) was obtained from the GEO database GSE90891 (*f* = a floxed allele of
622 the indicated genes).

623 25) **CCLE 2018** (PMID: 22460905; DOI: 10.1038/nature11003)[31]: RNAseq data of 1,019 human cell lines
624 were obtained from the Xena Functional Genomics Portal[71] (https://xenabrowser.net, version: 2018-
625 05-30; ref. 71). Among them, eight prostate cancer cell lines — DU145 (RRID:CVCL_0105), LNCaP
626 clone FGC (RRID:CVCL_1379), MDA PCa 2b (RRID:CVCL_4745), NCI-H660 (RRID:CVCL_0459),
627 PC-3 (RRID:CVCL_0035), VCaP (RRID:CVCL_2235), 22Rv1 (RRID:CVCL_1045), and PRECLH
628 (PrEC LH; RRID:CVCL_V626) — were included for analysis.

629 26) **XG-LNCaP** and **XG-LAPC9** (PMID: 30190514; DOI: 10.1038/s41467-018-06067-7)[34]: RNAseq data
630 of 12 LNCaP xenografts (XG-LNCaP) and 10 LAPC9 xenografts (XG-LAPC9) was obtained from the
631 GEO database GSE88752.

632

633 <u>Sex as a biological variable</u>

634 All clinical datasets analyzed in this study consisted exclusively of male patients, consistent with the male-
635 specific nature of prostate cancer. Preclinical models, including xenografts, patient-derived xenografts, and
636 genetically engineered mouse models (GEMMs), were also male-derived. All prostate cancer cell lines

637 utilized in the study were of male origin, with the exception of Supplementary Figure S5A, where a broader
638 cohort of 1,019 cell lines from the Cancer Cell Line Encyclopedia (CCLE), comprising both male- and
639 female-derived samples across multiple cancer types, was analyzed. Analyses of CCLE data in
640 Supplementary Figure S5A were performed without stratification by sex.
641
642 **Transcriptomic data normalization and transcriptome-based signature scores**
643 To ensure consistency and compatibility across diverse datasets, we employed normalization strategies
644 tailored to the specific data types and analytical approaches.
645 Canonical AR activity score (AR-A), MYC activity score (MYC-sig), and PCa-Stem signature: Canonical
646 pro-differentiation AR-A can be determined by RNA-seq based measurements of AR-regulated transcripts
647 under intact androgen/AR signaling conditions. Similarly, MYC-sig can be determined by MYC-regulated
648 transcripts. We employed Z-score normalization method[72] to determine AR-A and MYC-sig. Briefly, the
649 numeric AR or MYC activity score was calculated based on a linear combination of expression values (Z-
650 scores) of experimentally validated AR targets[14] or MYC targets[51] (Supplementary Table S2, GSEA
651 Molecular Signature Database 2022.1 version, MSigDB). The target gene lists were detailed in
652 Supplementary Table S2. The expression value for each AR or MYC target genes (Supplementary Table
653 S2) was converted to Z-score by $Z = (x - \mu)/\sigma$, where x is the expression value of the target gene in a
654 specific sample, μ is the mean and σ is the standard deviation across all samples of a gene. Finally, the
655 combined Z-scores were summed across all genes to represent the expression score of canonical AR or
656 MYC target genes. Analysis of gene expression signatures using Z-score normalization (AR-A and MYC-
657 sig) was confined within individual datasets, obviating the need for cross-dataset comparisons.
658 To further minimize batch effects and ensure data integrity and comparability across PCa stages,
659 normalized RNAseq data from a published integrated data framework, the Prostate Cancer Transcriptome
660 Atlas[27] (https://prostatecanceratlas.org), was used. In this harmonized resource, raw RNAseq data with
661 high-quality sequencing reads from different datasets were re-mapped to the human reference genome
662 GRCh38, adjusted for library size, and normalized using the variance stabilizing transformation pipeline
663 using DESeq2 (version 1.28.1; RRID:SCR_015687)[27].
664 Single-sample gene set enrichment analysis (ssGSEA) was performed using the Gene Set
665 Variation Analysis (GSVA)[73] package (version 1.50.5; RRID:SCR_021058) (73) in R (version 4.3.3;
666 RRID:SCR_001905) to calculate scores for the in-house derived 12-gene PCa-Stem signature
667 (Supplementary Table S2) across different stages of PCa progression using the normalized RNAseq data
668 from Bolis *et al.,* 2021[27] (Prostate Cancer Transcriptome Atlas; see details in "PCa clinical datasets and
669 data collection" in the Methods section).
670
671 Transcriptome-based quantitative measurement of oncogenic stemness (the Stemness Index): We
672 adapted mRNA-based Stemness Index (mRNAsi) to determine the degree of oncogenic dedifferentiation

673 (Stemness)[6]. Briefly, we computed Spearman correlations between the stemness model's weight vector
674 and the transcriptome expression profile of the queried samples, assuming paired observations, at least
675 ordinal scale data, and a monotonic relationship without significant outliers. Spearman correlation
676 calculations were performed using the 'stats' package (version 4.3.3) in R (version 4.3.3;
677 RRID:SCR_001905). The resulting correlation coefficients were then linearly transformed to scale the
678 mRNAsi scores between 0 and 1 using the following formula: Stemness Index = (Spearman correlation +
679 0.2619) /0.4151. Spearman correlation is advocated for calculating the Stemness Index because it is more
680 robust with respect to potential cross-dataset batch effects that may arise[6].
681

682 **Integrative analysis of genomic alterations in primary PCa (TCGA) and mCRPC (SU2C)**

683 To explore molecular and clinical features associated with Stemness, we performed integrative analysis of
684 genomic, transcriptomic, clinicopathologic, and outcome data using cBioPortal for Cancer Genomics
685 (RRID:SCR_014555), which provides interactive access to multidimensional cancer genomics datasets
686 and integrated visualization tools[74]. Specifically, we analyzed data from primary prostate cancer (Pri-PCa;
687 **TCGA-PRAD 2018**, Pan-Cancer Atlas) and metastatic castration-resistant PCa (mCRPC; **SU2C 2019**)
688 cohorts. Clinicopathologic variables (e.g., age, Gleason scores, PSA levels, tumor stage), genomic
689 alterations (e.g., mutation frequency, TMB, fraction genome altered, CNAs, and SVs), and patient outcome
690 data (e.g., overall survival, progression-free survival) were retrieved from cBioPortal (RRID:SCR_014555)
691 as described in the "PCa clinical datasets and data collection" section. Transcriptomic data used for
692 Stemness score calculation were obtained as described in the same section. For comparative analysis,
693 mCRPC samples were stratified into top and bottom 33% by Stemness score. In TCGA, only treatment-
694 naïve Pri-PCa samples were used for a similar 33% stratification, excluding 70 patients who had received
695 adjuvant (post-surgery) hormone therapy to reflect spontaneous disease progression. Differential
696 expression analysis was conducted using DESeq2[75] (version 1.42.1; RRID:SCR_015687), and gene-level
697 and genome-wide alteration frequencies were assessed across stratified groups and disease stages (e.g.,
698 Pri-PCa vs. mCRPC) using OncoPrint visualizations, bar plots, and correlation analysis. Associations with
699 clinical outcomes were evaluated as described in the "Statistical analysis" section.
700

701 **Statistical analysis**

702 Statistical analyses were performed using GraphPad Prism software (version 10.4.1 (532);
703 RRID:SCR_002798) and R (version 4.3.3; RRID:SCR_001095).
704 For comparisons between two groups, independent sample or paired *t*-tests were used to compare
705 group means, assuming normality and equal variance. For multiple-group comparisons, Tukey's range test
706 was employed following one-way ANOVA (adjusted p-values are listed in Supplementary Table S4). The
707 Wilcoxon rank-sum test was applied for comparisons of altered genome fraction, TMB, or age between
708 two groups.

709 For differential expression analyses and comparisons involving multiple hypotheses (e.g., RNAseq-
710 based gene comparisons), p-values were further adjusted using the false discovery rate (FDR) method to
711 control for multiple testing.
712 Pearson's correlation coefficient was used to evaluate linear associations between two continuous
713 variables, assuming normally distributed paired observations. Linear regression modeling was applied to
714 examine the relationship between two continuous variables, with the slope of the best-fit regression line
715 reported where applicable. Spearman's rank correlation was employed to assess monotonic relationships
716 between continuous or ordinal variables, assuming paired observations and monotonic trends without
717 significant outliers.
718 The Jonckheere-Terpstra (J-T) trend test was used to assess monotonic association between an
719 ordinal variable and a continuous variable. Chi-square test or Fisher's exact test was performed to evaluate
720 the associations between categorical variables.
721 For the analysis of patient progression-free survival (PFS), recurrence-free survival (RFS) and
722 overall survival (OS), the standard Kaplan-Meier method was used for the estimation of survival fractions
723 and log-rank tests were used for group comparisons. Cox proportional hazards models were used for
724 multivariable analysis and for assessing the prognostic significance of gene signatures (Stemness, PCa-
725 Stem signature, etc). For the mRNA-based gene signatures (Stemness, PCa-Stem signature, AR-A),
726 patients were stratified into high and low signature groups based on median split in cohorts including Spratt
727 2017 (Fig. 4C), Tosoian 2020 (Fig. 4C), CHAARTED 2021 (Supplementary Fig. S6C), Taylor 2010
728 (Supplementary Fig. S6C), TCGA-PRAD 2018 (Supplementary Fig. S6C), and SU2C 2019
729 (Supplementary Fig. S6C). For certain analyses, including SU2C 2019 (Supplementary Fig. S6C) and
730 CHAARTED 2021 (Fig. 4C), patients were alternatively stratified by comparing the top 25% versus the
731 bottom 75% of signature scores to assess whether patients with very high Stemness levels exhibited a
732 higher risk of disease progression.
733 All statistical tests were two-sided, and $P < 0.05$ was considered statistically significant.
734
735 **Data and Code Availability**
736 All datasets and computational codes supporting the findings of this study are described below.
737 Code Availability: Custom R scripts used for data preprocessing, differential expression analysis, gene
738 signature quantification, and survival/statistical modeling are available from the corresponding author upon
739 reasonable request.
740 Data Availability: All datasets analyzed in this study are publicly available from repositories including GEO
741 (RRID:SCR_005012), cBioPortal (RRID:SCR_014555), the NCI GDC Portal, Xena Functional Genomics
742 Portal (RRID:SCR_018938), EGA (RRID:SCR_004944), ENA (RRID:SCR_006515), and Zenodo
743 (RRID:SCR_004129), as detailed in Supplementary Table S1.

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903

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Ethics declarations

Competing interests

All authors declare no competing interests relative to this work.

Figure Legends

Figure 1. *Pri-PCa shows concordant increases of AR-A and Stemness and both are decreased by nADT.*

A-C, PCa has increased AR-A as well as the Stemness compared to matched benign tissues. Pairwise comparisons of *AR* mRNA levels, canonical AR-A, and Stemness scores showing significant increases in primary tumors (T) as compared to the matched adjacent benign prostate tissues (N) from the same individual in TCGA-PRAD cohort (n=51; **A**), and Wyatt 2014 cohort (n=12; **B**). In the Long 2020 cohort (n=10; **C**), increases in AR-A and Stemness reached statistical significance whereas the increase in *AR* mRNA levels approached statistical significance ($P = 0.06$).

D-F, nADT decreases both AR-A and Stemness. Pairwise comparison of *AR* mRNA levels, AR-A, and Stemness showing significant decrease of both AR-A and Stemness after nADT (Post-nADT) as compared to the matched samples before nADT (Pre-nADT) from the same individual (**D**, Rajan 2014 cohort; **E**, Sharma 2018 cohort; **F**, Long 2020 cohort).

In all plots, sample sizes are indicated (see also Supplementary Table S1 for cohort and RNA-seq data access information). Within the plots, results are shown as the mean ± SD and pairs are linked with a grey line. Significance was calculated by two-tailed paired Student's *t*-test (ns, not significant; *, $P < 0.05$; **, $P < 0.01$; ***, $P < 0.001$; ****, $P < 0.0001$).

Figure 2. *Continual increases in Stemness with declining AR-A during spontaneous PCa progression*.

A, The pie chart showing sample sizes in different Gleason grades in the TCGA untreated Pri-PCa cohort.

B-D, Progression of treatment-naïve Pri-PCa is accompanied by decreasing AR-A but increasing Stemness. Data is presented as mean ± SD. Shown on top are the Jonckheere-Terpstra's trend (J-T) test results (wedges).

E-F, Progression in Pri-PCa is accompanied by a gradual loss of the positive correlation between canonical AR-A and Stemness. Scatter plots illustrating the correlation between AR-A and Stemness in (**E**) combined Pri-PCa cases in TCGA with an overall linear regression model and (**F**) individual GS grades with corresponding linear regressions showing decreasing slopes from low to high GS grades by J-T test. The slopes of best-fit regression line are also shown.

G, Merged scatter plot showing the correlation between AR-A and Stemness across the 4 GS PCa with each GS represented by a distinct color. The correlation becomes progressively weaker from GS6 to GS9/10, transitioning from positive to nearly zero. The correlation coefficients (r) and p-values for each GS are as follows: GS6 ($r = 0.56$, $P < 0.0001$), GS7 ($r = 0.37$, $P < 0.0001$), GS8 ($r = 0.48$, $P = 0.022$), and GS9/10 ($r = -0.02$, $P = 0.89$). Linear regression lines are overlaid for each GS, demonstrating the decline in the correlation co-efficiency as the GS increases.

All statistical analyses were performed using R and statistical significance was assessed using one-way analysis of variance followed by Tukey's multiple-comparison test (B-D). J-T trend test in B-D and F was used to calculate the statistical significance of the trend across different groups. *, $P < 0.05$; **, $P < 0.01$; ***, $P < 0.001$; ****, $P < 0.0001$; ns, not significant.

Figure 3. *Therapies and metastatic progression drive further divergence between Stemness and canonical AR-A with mCRPC showing the highest Stemness but the lowest AR-A*.

A-D, Hormonal treatment further drives down AR-A but significantly upregulates Stemness. **A-C**, mCRPC displays the lowest pro-differentiation AR-A but highest Stemness. Shown are *AR* mRNA levels (**A**), the canonical AR-A (**B**) and Stemness (**C**) in tumor-adjacent benign tissues (N), treatment-naïve Pri-PCa and advanced Pri-PCa with post-surgery adjuvant ADT (Tx) in TCGA, and mCRPC (SU2C 2015). Sample sizes are indicated in parentheses. Shown on top are the Jonckheere-Terpstra's (J-T) trend test results (wedges). **D,** Stemness inversely correlates with AR-A in mCRPC**.** Shown are scatter plots with best-fit linear regression lines illustrating the correlation between AR-A and Stemness with Pearson correlation coefficient (r), the slopes of lines and J-T test results of slopes indicated below.

E-F, PCa progression is accompanied by loss of AR-A (**E**) but gain of Stemness (**F**) across PCa states. Shown are samples representing the spectrum of PCa development and progression, from normal (organ donors in GTEx) to (tumor-adjacent) benign tissues, to (treatment-naïve) Pri-PCa, aggressive Pri-PCa treated with

adjuvant ADT (Pri-PCa/ADT), mCRPC, and, finally, to (clonally-derived) PCa models including PDX, xenografts and cells lines. From Left to right: Normal (n=116): Normal prostates from GTEx; Benign (n=52): tumor-adjacent benign tissue from TCGA-PRAD; Pri-PCa (n=422): treatment-naïve localized PCa from TCGA-PRAD; Pri-PCa/ADT (n=70): advanced Pri-PCa treated with adjuvant hormone therapy from TCGA-PRAD; mCRPC (n=59): mCRPC from GSE126078; mCRPC (n=135): mCRPC from SU2C 2015 cohort; mCRPC-Adeno (n=34): adenocarcinoma mCRPC from Beltran 2016 cohort; mCRPC-NE (n=15): neuroendocrine mCRPC from Beltran 2016 cohort; mCRPC (n=42): mCRPC from Westbrook 2022; mCRPC (n=25): mCRPC from Alumkal 2020; PDX-LuCaP (n=39): PCa PDXs from GSE126078; PCa cell lines (n=8): PCa cell lines from CCLE; XG-LAPC9 (n=10) and XG-LNCaP (n=12): PCa xenografts from GSE88752. Statistical significances between groups were shown in inverted pyramid grid plot as indicated by different colors. Student's *t*-test was used to compare each group and adjusted p-value for multiple comparisons was done by Tukey's range test. See Supplementary Table S4 for the summary of statistical comparisons. J-T trend test was used to assess the statistical significance of the trend across groups. See also Supplementary Table S1 for cohort and RNA-seq data access information.

G, Scatter plots in the Bolis 2021 integrated cohort (normal n=174, Pri-PCa n=714, mCRPC n=335) showing the changing correlation between AR-A and Stemness across disease stages: positive in normal to weaker correlations in Pri-PCa to negative correlations in mCRPC. Regression lines are color-coded, and the slope of the best-fit regression line and Pearson's r are provided: yellow for normal (Pearson's r=0.42, P <0.0001; slope: 43.87, 95%CI, 29.57 to 58.18); blue for Pri-PCa (r=0.32, P <0.0001; slope: 15.04, 95%CI, 11.76 to 18.32); and green for mCRPC (r=-0.15, P = 0.005; slope: -17.25, 95%CI, -29.24 to -5.26).

H, Violin plot showing increasing Stemness among the NCCN Risk Groups containing 82470 microarray samples with localized disease in GRID. J-T trend test was used to assess the statistical significance of the trend across groups.

I-M, Increasing Stemness during PCa progression in the Taylor 2010 cohort consisting of tumor-adjacent benign tissue (Normal; n=29), Pri-PCa (n=131) and metastatic mPCa (n=19). The AR-A significantly increased in Pri-PCa vs. Normal and significantly decreased in mPCa compared to Pri-PCa (**I**) whereas the Stemness continued to increase from Benign to Pri-PCa to mPCa (**J**). **K-M**, Scatter plots illustrating the correlations between AR-A and Stemness in different contexts with corresponding linear regression lines: **K,** Positive correlation in normal (Pearson's r=0.69, P <0.0001); **L,** a gradual loss of positive correlation between Stemness and AR-A during PCa progression (Pearson's r=0.18, P = 0.043); **M,** a loss of positive correlation between the Stemness and AR-A at more advanced mPCa stage (Pearson's r=0.18, P =0.47).

All data in dot plots and violin plots are shown as mean ± SD. Statistical significance was determined using one-way analysis of variance (ANOVA) followed by Tukey's multiple-comparison test. Jonckheere-Terpstra's trend (J-T) test was used to calculate the statistical significance of the trend across different groups. Pearson correlation coefficients (Pearson's r) were used to calculate the correlations between the Stemness and AR-A. Note: ns, not significant; *, P < 0.05; **, P < 0.01; ***, P < 0.001; ****, P < 0.0001.

Figure 4. *High Stemness is associated with poor patient overall survival.μ*

A-C, Kaplan-Meier plots showing that high Stemness associates with worse overall survival in PCa patients from Spratt 2017 (**A**), Tosoian 2020 (**B**), and CHAARTED 2021 (**C**) cohorts. P value was determined using the log-rank test.

D, Stemness increases across patient groups with higher Decipher genomic classifier scores. The three cohorts were arranged by their median Decipher genomic classifier scores, and the J-T trend test was used to assess statistical significance of this trend.

Figure 5. *Stemness-high PCa are associated with aggressive molecular subtypes and a 12-gene PCa-stem signature prognosticates poor patient survival.*

A, Schematic illustrating the profiling strategy used to assess associations between Stemness and molecular features in PCa. Patients were ranked by Stemness score and stratified into Stemness-high (top 33%) and Stemness-low (bottom 33%) groups for downstream analyses. Genome-wide functional analyses were performed using transcriptomic, genomic, and clinical data.

B-C, Volcano plots showing differentially expressed genes (DEGs) between Stemness-high and Stemness-low groups in Pri-PCa (**B**) and mCRPC (**C**) cohorts. Red and blue indicate upregulated and downregulated DEGs, respectively. Genes with FDR > 0.05 are shown in gray. Sample sizes (n) of each group are indicated. See Supplementary Table S3 for complete DEG lists.

D Venn diagram showing the 12-gene "PCa-Stem signature" derived from overlapping upregulated DEGs (FC ≥ 2, FDR < 0.05) in both Pri-PCa and mCRPC.

E-F, GSEA showing low Stemness is associated with immune signaling and inflammatory response (**E**) while high Stemness in both cohorts is enriched for embryonic stem cell traits, aggressiveness, DNA repair, MYC activation, and mTORC1 signaling (**F**). All enrichments are significant ($P < 0.05$, FDR < 0.05).

G-H, PAM50 subtyping showing a higher frequency of LumB subtype in Stemness-high versus Stemness-low samples in Pri-PCa (**G**) and mCRPC (**H**). (****, $P < 0.0001$, χ^2 test).

I-L, GSEA showing enrichment of the aggressive PCS1 gene expression signature in Stemness-high groups and the less aggressive PCS3 signature in Stemness-low groups in Pri-PCa (**I**, **K**) and mCRPC (**J**, **L**). The Prostate Cancer Subtype (PCS) classification system (45,46) stratifies tumors into three molecular subtypes based on transcriptomic features: PCS1 (most aggressive), PCS2 (intermediate), and PCS3 (least aggressive). See Supplementary Table S2 for PCS gene signature.

M-R, GSEA showing AR signature enrichment in Pri-PCa Stemness-high (**M**), NEPC signature enrichment in mCRPC Stemness-high (**N**), and shared enrichment of cell cycle (**O**, **P**) and lineage plasticity (**Q**, **R**) programs in both cohorts. See Supplementary Table S5 for gene sets.

S-V, Kaplan-Meier analyses showing that the 12-gene PCa-Stem signature predicts worse progression-free survival (PFS) in TCGA Pri-PCa (**S**) and worse overall survival (OS) in SU2C mCRPC (**U**). Multivariable Cox models adjusting for clinicopathologic variables confirm the PCa-Stem-High subgroup as independently prognostic for PFS (**T**) and OS (**V**).

Figure 6. *Stemness-high PCa is associated with higher genomic instability.*

A-C, Box plots showing that Stemness-high subgroup in both Pri-PCa (n = 141) and mCRPC (n = 89) displays a higher fraction of altered genome (**A**), higher TMB (**B**), and no age difference compared to Stemness-low cases (**C**). Wilcoxon rank-sum test was used to determine significance (****, $P < 0.0001$; ns, not significant). Statistical significance was determined using the two-sided Wilcoxon rank-sum test. Box plots represent the median, interquartile range (IQR), and whiskers extending to 1.5× the IQR.

D-F, Comparisons of genomic alteration frequencies (Alt. Freq) in cancer-associated genes between Stemness-high and Stemness-low subgroups in TCGA Pri-PCa (**D**, **F**) and SU2C mCRPC (**E**, **F**) cohorts. Statistical significance was determined by two-sided Fisher's Exact test (*, $P < 0.05$).

Figure 7. *MYC activation contributes to increased Stemness during spontaneous PCa progression.*

A-B, Pairwise comparisons showing increased *MYC* mRNA levels and MYC activity (MYC-sig) in primary tumors (T) versus matched adjacent benign tissues (N) in TCGA-PRAD cohort (n=51; **A**) and Wyatt (n=12; **B**) cohorts. Data is shown as mean ± SD; paired samples are linked by grey lines. Significance was determined using two-tailed paired Student's *t*-test (****, $P < 0.0001$).

C-H, MYC activity increases during PCa progression, peaking in mCRPC. In treatment-naïve Pri-PCa (**C**), MYC-sig is significantly increased in all-grade (GS) tumors as compared to tumor-adjacent benign tissues (N) with the most advanced GS9/10 tumors exhibiting the highest MYC-sig. In **D**, MYC-sig increases from normal to treatment-naïve Pri-PCa and further in advanced Pri-PCa treated with adjuvant ADT (Tx) in TCGA-PRAD, while mCRPC shows the highest MYC-sig in both SU2C 2015 (**D**) and Taylor 2010 (**E**) cohorts. Data is presented as mean ± SD. Statistical significance was assessed by one-way ANOVA with Tukey's multiple-comparison test (**C-E**). J-T trend test was used in (C, D) to assess the significance of progressive increase. **, $P < 0.01$; ***, $P < 0.001$; ****, $P < 0.0001$; ns, not significant. **F-H,** Scatter plots showing positive correlations between MYC activity and Stemness in the Taylor 2010 cohort across different stages. Pearson's r and P-values are indicated.

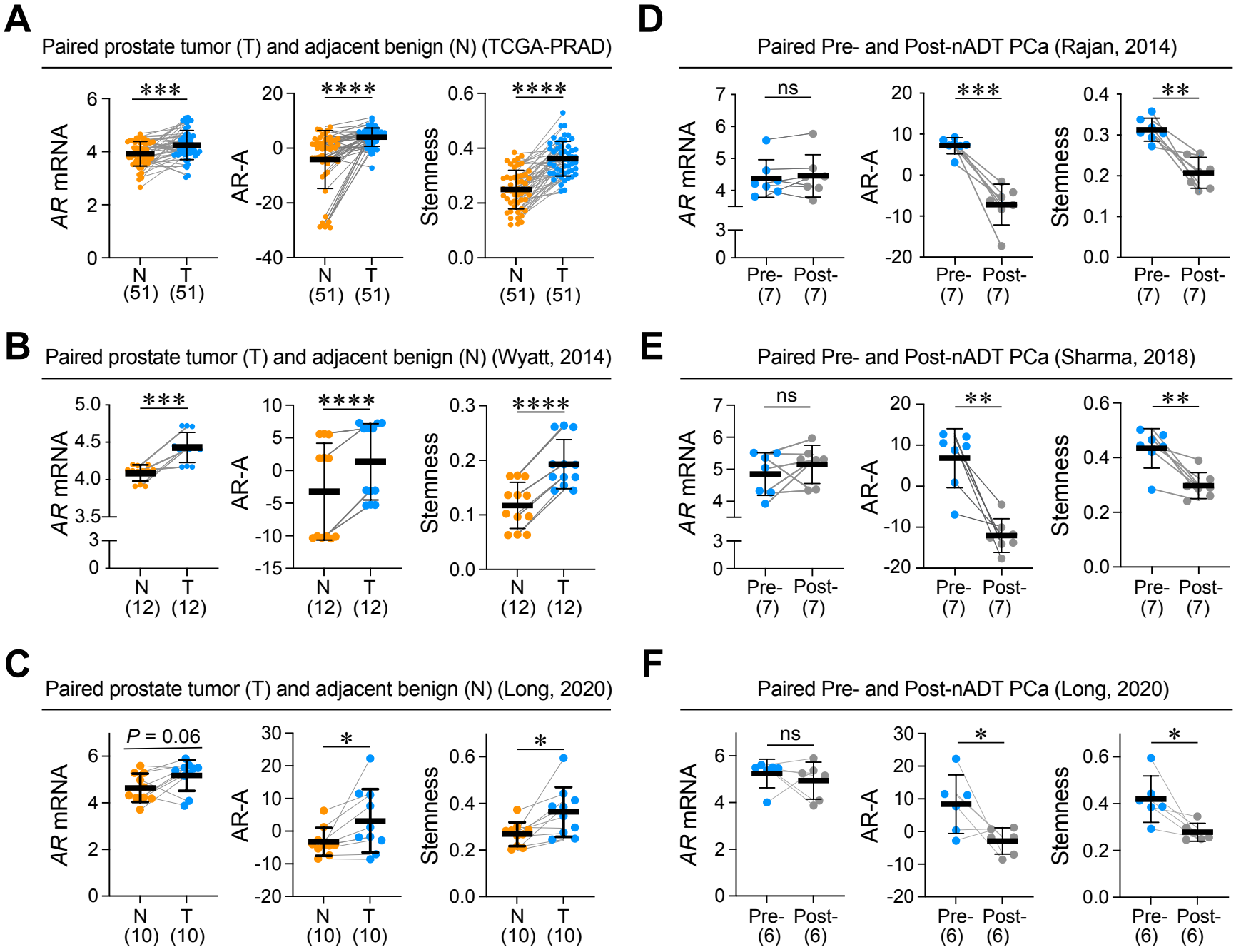

A
Paired prostate tumor (T) and adjacent benign (N) (TCGA-PRAD)
AR mRNA
AR-A
Stemness
***
****
****
N (51)
T (51)
B
Paired prostate tumor (T) and adjacent benign (N) (Wyatt, 2014)
***
****
****
N (12)
T (12)
C
Paired prostate tumor (T) and adjacent benign (N) (Long, 2020)
P = 0.06
*
*
N (10)
T (10)
D
Paired Pre- and Post-nADT PCa (Rajan, 2014)
ns
***
**
Pre- (7)
Post- (7)
E
Paired Pre- and Post-nADT PCa (Sharma, 2018)
ns
**
**
Pre- (7)
Post- (7)
F
Paired Pre- and Post-nADT PCa (Long, 2020)
ns
*
*
Pre- (6)
Post- (6)

Figure 1

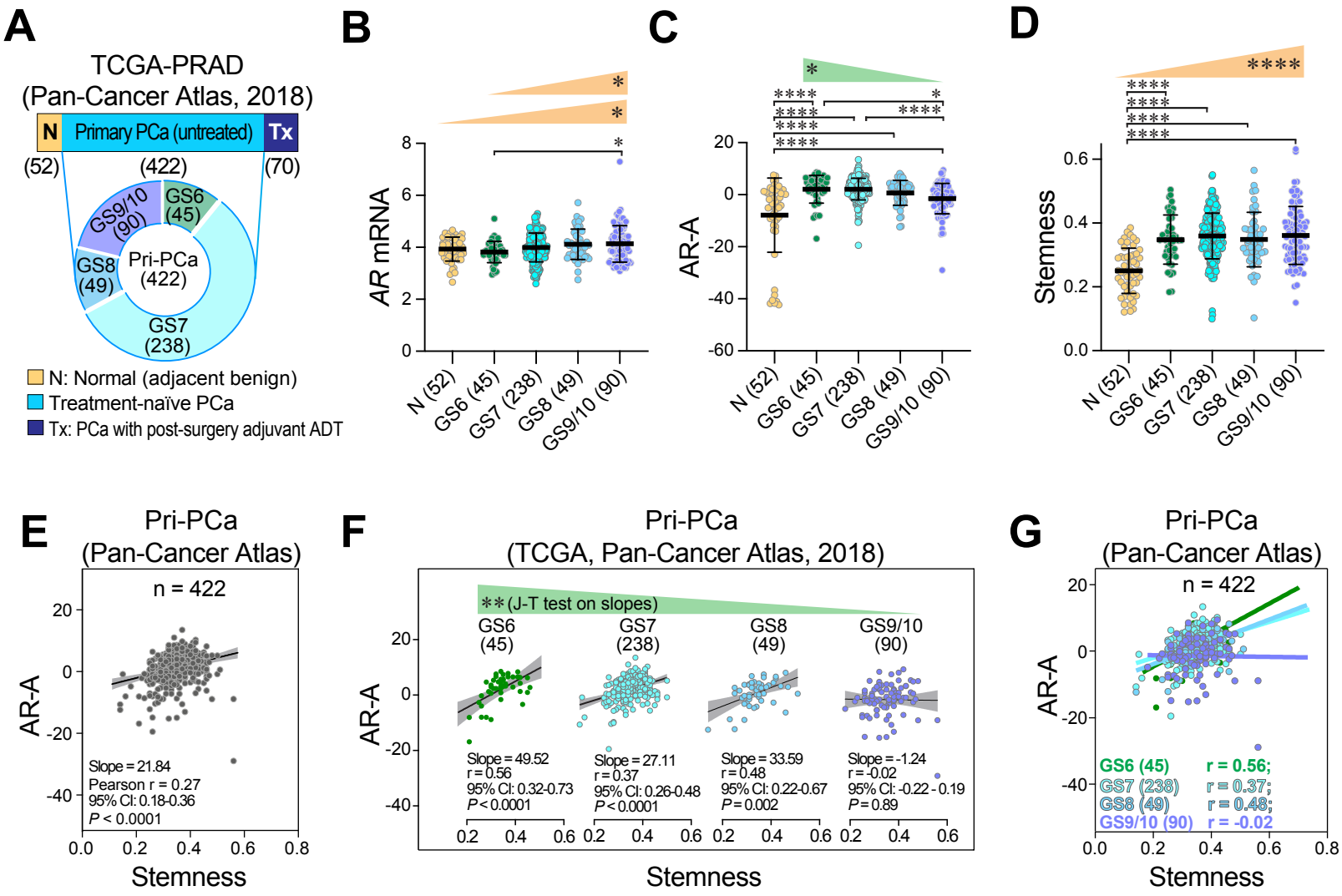

A
TCGA-PRAD
(Pan-Cancer Atlas, 2018)
N
Primary PCa (untreated)
Tx
(52)
(422)
(70)
GS9/10 (90)
GS6 (45)
GS8 (49)
Pri-PCa (422)
GS7 (238)
N: Normal (adjacent benign)
Treatment-naïve PCa
Tx: PCa with post-surgery adjuvant ADT
B
AR mRNA
N (52)
GS6 (45)
GS7 (238)
GS8 (49)
GS9/10 (90)
C
AR-A
D
Stemness
E
Pri-PCa
(Pan-Cancer Atlas)
n = 422
AR-A
Slope = 21.84
Pearson r = 0.27
95% CI: 0.18-0.36
P < 0.0001
Stemness
F
Pri-PCa
(TCGA, Pan-Cancer Atlas, 2018)
** (J-T test on slopes)
GS6 (45)
GS7 (238)
GS8 (49)
GS9/10 (90)
Slope = 49.52
r = 0.56
95% CI: 0.32-0.73
P < 0.0001
Slope = 27.11
r = 0.37
95% CI: 0.26-0.48
P < 0.0001
Slope = 33.59
r = 0.48
95% CI: 0.22-0.67
P = 0.002
Slope = -1.24
r = -0.02
95% CI: -0.22 - 0.19
P = 0.89
Stemness
G
Pri-PCa
(Pan-Cancer Atlas)
n = 422
AR-A
GS6 (45) r = 0.56;
GS7 (238) r = 0.37;
GS8 (49) r = 0.48;
GS9/10 (90) r = -0.02
Stemness

Figure 2

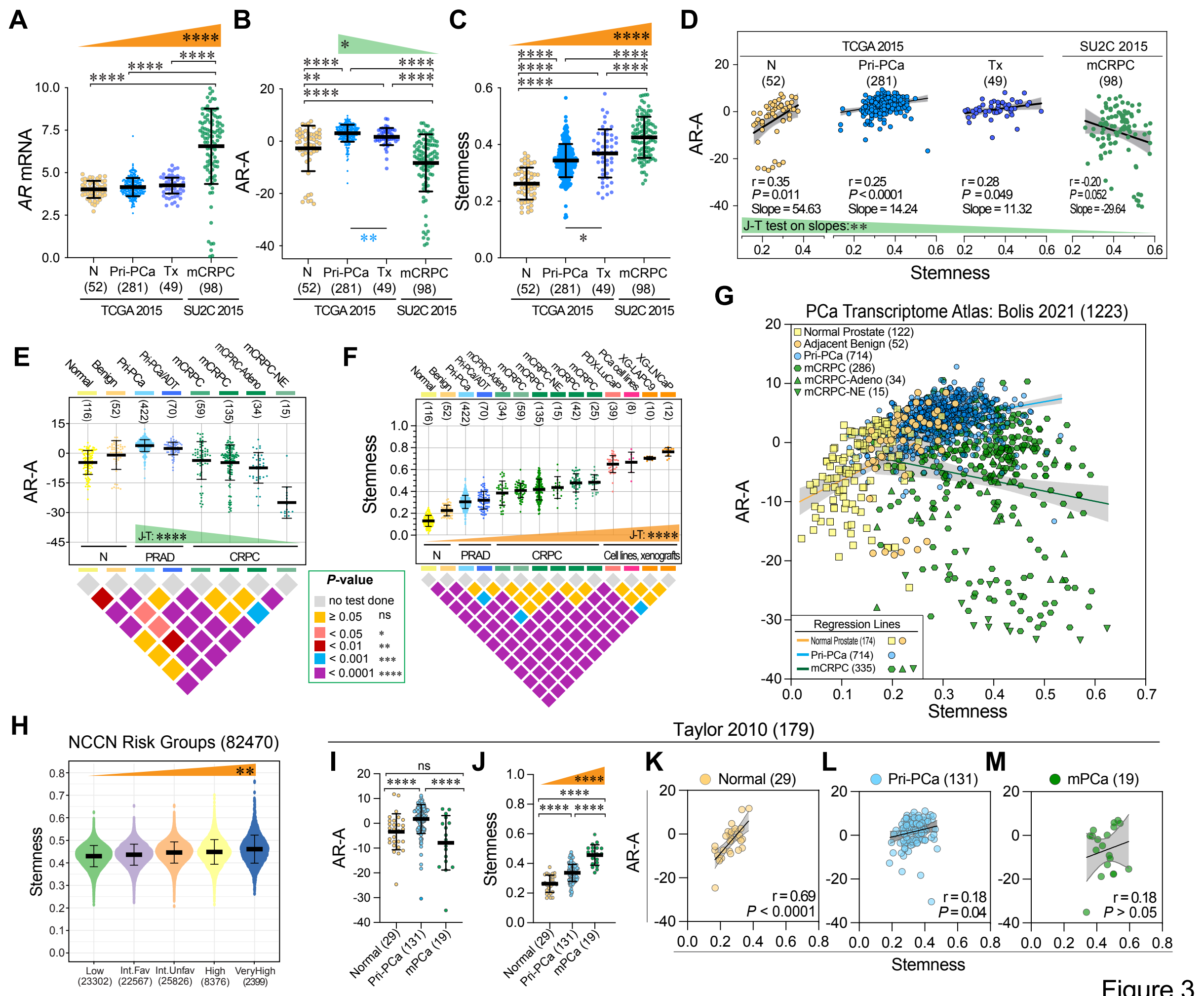

A
AR mRNA
N (52)
Pri-PCa (281)
Tx (49)
mCRPC (98)
TCGA 2015
SU2C 2015
B
AR-A
C
Stemness
D
TCGA 2015
SU2C 2015
r = 0.35
P = 0.011
Slope = 54.63
r = 0.25
P < 0.0001
Slope = 14.24
r = 0.28
P = 0.049
Slope = 11.32
r = -0.20
P = 0.052
Slope = -29.64
J-T test on slopes: **
E
Normal
Benign
Pri-PCa
Pri-PCa/ADT
mCRPC
mCRPC
mCRPC-Adeno
mCRPC-NE
J-T: ****
N
PRAD
CRPC
P-value
no test done
≥ 0.05 ns
< 0.05 *
< 0.01 **
< 0.001 ***
< 0.0001 ****
F
Cell lines, xenografts
G
PCa Transcriptome Atlas: Bolis 2021 (1223)
Normal Prostate (122)
Adjacent Benign (52)
Pri-PCa (714)
mCRPC (286)
mCRPC-Adeno (34)
mCRPC-NE (15)
Regression Lines
Normal Prostate (174)
Pri-PCa (714)
mCRPC (335)
H
NCCN Risk Groups (82470)
Low (23302)
Int.Fav (22567)
Int.Unfav (25826)
High (8376)
VeryHigh (2399)
Taylor 2010 (179)
I
J
K
Normal (29)
L
Pri-PCa (131)
M
mPCa (19)
r = 0.69
P < 0.0001
r = 0.18
P = 0.04
r = 0.18
P > 0.05

Figure 3

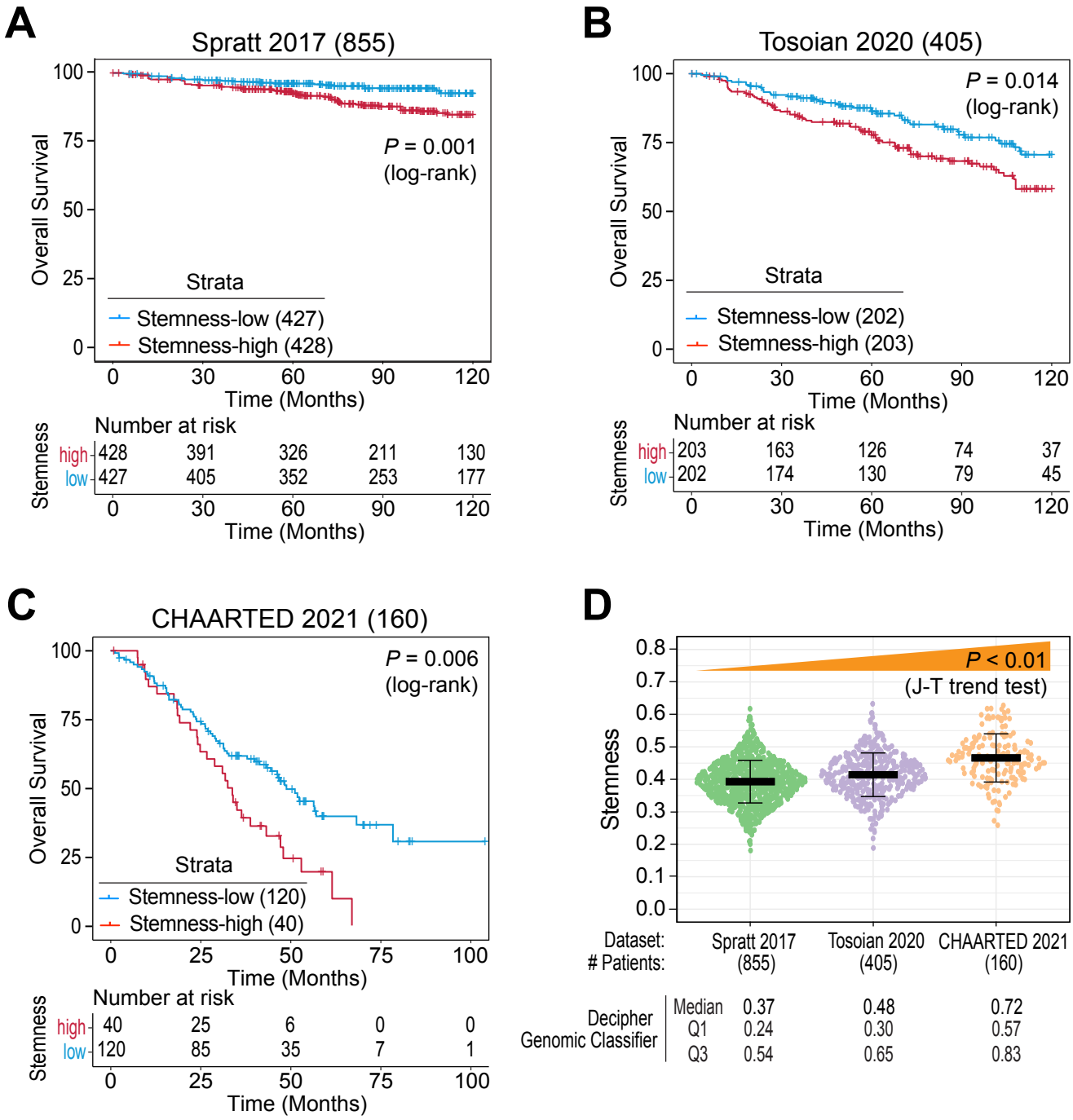

A
Spratt 2017 (855)
Overall Survival
P = 0.001
(log-rank)
Strata
Stemness-low (427)
Stemness-high (428)
Time (Months)
Number at risk
Stemness
high 428 391 326 211 130
low 427 405 352 253 177
B
Tosoian 2020 (405)
P = 0.014
(log-rank)
Stemness-low (202)
Stemness-high (203)
high 203 163 126 74 37
low 202 174 130 79 45
C
CHAARTED 2021 (160)
P = 0.006
(log-rank)
Stemness-low (120)
Stemness-high (40)
high 40 25 6 0 0
low 120 85 35 7 1
D
P < 0.01
(J-T trend test)
Stemness
Dataset:
Patients:
Spratt 2017 (855)
Tosoian 2020 (405)
CHAARTED 2021 (160)
Decipher Genomic Classifier
Median 0.37 0.48 0.72
Q1 0.24 0.30 0.57
Q3 0.54 0.65 0.83

Figure 4

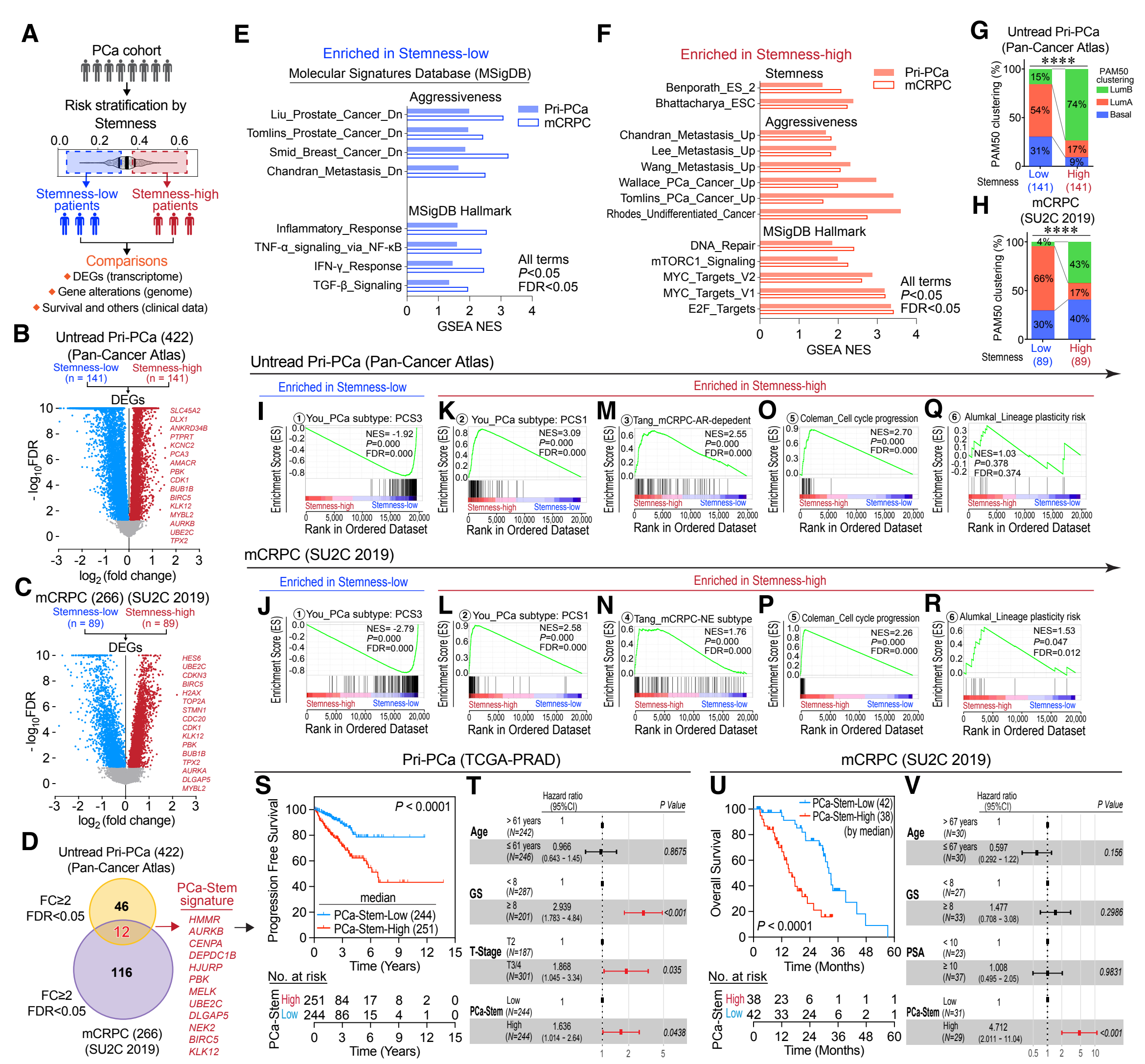

A
PCa cohort
Risk stratification by Stemness
0.0 0.2 0.4 0.6
Stemness-low patients
Stemness-high patients
Comparisons
DEGs (transcriptome)
Gene alterations (genome)
Survival and others (clinical data)
B
Untread Pri-PCa (422) (Pan-Cancer Atlas)
Stemness-low (n = 141)
Stemness-high (n = 141)
DEGs
SLC45A2 DLX1 ANKRD34B PTPRT KCNC2 PCA3 AMACR PBK CDK1 BUB1B BIRC5 KLK12 MYBL2 AURKB UBE2C TPX2
-log10FDR
log2 (fold change)
C
mCRPC (266) (SU2C 2019)
Stemness-low (n = 89)
Stemness-high (n = 89)
DEGs
HES6 UBE2C CDKN3 BIRC5 H2AX TOP2A STMN1 CDC20 CDK1 KLK12 PBK BUB1B TPX2 AURKA DLGAP5 MYBL2
-log10FDR
log2 (fold change)
D
Untread Pri-PCa (422) (Pan-Cancer Atlas)
FC≥2 FDR<0.05
46
12
116
FC≥2 FDR<0.05
mCRPC (266) (SU2C 2019)
PCa-Stem signature
HMMR AURKB CENPA DEPDC1B HJURP PBK MELK UBE2C DLGAP5 NEK2 BIRC5 KLK12
E
Enriched in Stemness-low
Molecular Signatures Database (MSigDB)
Aggressiveness
Liu_Prostate_Cancer_Dn
Tomlins_Prostate_Cancer_Dn
Smid_Breast_Cancer_Dn
Chandran_Metastasis_Dn
MSigDB Hallmark
Inflammatory_Response
TNF-α_signaling_via_NF-κB
IFN-γ_Response
TGF-β_Signaling
Pri-PCa
mCRPC
All terms P<0.05 FDR<0.05
GSEA NES
F
Enriched in Stemness-high
Stemness
Benporath_ES_2
Bhattacharya_ESC
Aggressiveness
Chandran_Metastasis_Up
Lee_Metastasis_Up
Wang_Metastasis_Up
Wallace_PCa_Cancer_Up
Tomlins_PCa_Cancer_Up
Rhodes_Undifferentiated_Cancer
MSigDB Hallmark
DNA_Repair
mTORC1_Signaling
MYC_Targets_V2
MYC_Targets_V1
E2F_Targets
Pri-PCa
mCRPC
All terms P<0.05 FDR<0.05
GSEA NES
G
Untread Pri-PCa (Pan-Cancer Atlas)
PAM50 clustering (%)
PAM50 clustering
LumB
LumA
Basal
Stemness
Low (141)
High (141)
H
mCRPC (SU2C 2019)
PAM50 clustering (%)
Stemness
Low (89)
High (89)
Untread Pri-PCa (Pan-Cancer Atlas)
Enriched in Stemness-low
Enriched in Stemness-high
I You_PCa subtype: PCS3 NES= -1.92 P=0.000 FDR=0.000
K You_PCa subtype: PCS1 NES=3.09 P=0.000 FDR=0.000
M Tang_mCRPC-AR-depedent NES=2.55 P=0.000 FDR=0.000
O Coleman_Cell cycle progression NES=2.70 P=0.000 FDR=0.000
Q Alumkal_Lineage plasticity risk NES=1.03 P=0.378 FDR=0.374
Enrichment Score (ES)
Stemness-high
Stemness-low
Rank in Ordered Dataset
mCRPC (SU2C 2019)
Enriched in Stemness-low
Enriched in Stemness-high
J You_PCa subtype: PCS3 NES= -2.79 P=0.000 FDR=0.000
L You_PCa subtype: PCS1 NES=2.58 P=0.000 FDR=0.000
N Tang_mCRPC-NE subtype NES=1.76 P=0.000 FDR=0.000
P Coleman_Cell cycle progression NES=2.26 P=0.000 FDR=0.000
R Alumkal_Lineage plasticity risk NES=1.53 P=0.047 FDR=0.012
Pri-PCa (TCGA-PRAD)
S
Progression Free Survival
P < 0.0001
median
PCa-Stem-Low (244)
PCa-Stem-High (251)
Time (Years)
No. at risk
PCa-Stem High 251 84 17 8 2 0
Low 244 86 15 4 1 0
T
Hazard ratio (95%CI)
P Value
Age > 61 years (N=242) 1
≤ 61 years (N=246) 0.966 (0.643 - 1.45) 0.8675
GS < 8 (N=287) 1
≥ 8 (N=201) 2.939 (1.783 - 4.84) <0.001
T-Stage T2 (N=187) 1
T3/4 (N=301) 1.868 (1.045 - 3.34) 0.035
PCa-Stem Low (N=244) 1
High (N=244) 1.636 (1.014 - 2.64) 0.0438
mCRPC (SU2C 2019)
U
Overall Survival
PCa-Stem-Low (42)
PCa-Stem-High (38)
(by median)
P < 0.0001
Time (Months)
No. at risk
PCa-Stem High 38 23 6 1 1 1
Low 42 33 24 6 2 1
V
Hazard ratio (95%CI)
P Value
Age > 67 years (N=30) 1
≤ 67 years (N=30) 0.597 (0.292 - 1.22) 0.156
GS < 8 (N=27) 1
≥ 8 (N=33) 1.477 (0.708 - 3.08) 0.2986
PSA < 10 (N=23) 1
≥ 10 (N=37) 1.008 (0.495 - 2.05) 0.9831
PCa-Stem Low (N=31) 1
High (N=29) 4.712 (2.011 - 11.04) <0.001

Figure 5

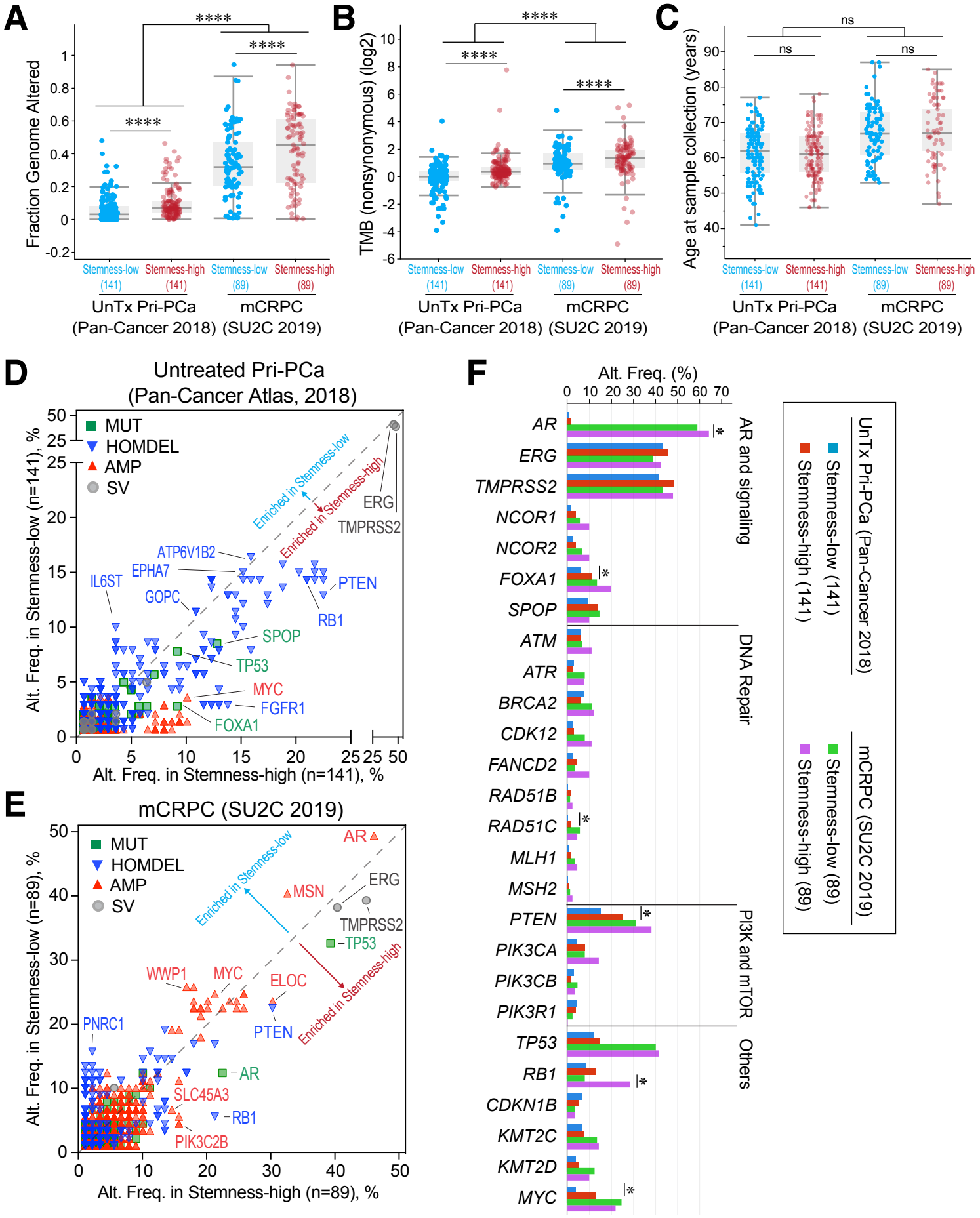

A
Fraction Genome Altered
****
****
****
Stemness-low (141)
Stemness-high (141)
Stemness-low (89)
Stemness-high (89)
UnTx Pri-PCa (Pan-Cancer 2018)
mCRPC (SU2C 2019)
B
TMB (nonsynonymous) (log2)
****
****
****
C
Age at sample collection (years)
ns
ns
ns
D
Untreated Pri-PCa (Pan-Cancer Atlas, 2018)
MUT
HOMDEL
AMP
SV
Enriched in Stemness-low
Enriched in Stemness-high
ERG
TMPRSS2
ATP6V1B2
EPHA7
IL6ST
GOPC
PTEN
RB1
SPOP
TP53
MYC
FGFR1
FOXA1
Alt. Freq. in Stemness-low (n=141), %
Alt. Freq. in Stemness-high (n=141), %
E
mCRPC (SU2C 2019)
MUT
HOMDEL
AMP
SV
Enriched in Stemness-low
Enriched in Stemness-high
AR
MSN
ERG
TMPRSS2
TP53
WWP1
MYC
ELOC
PNRC1
PTEN
AR
SLC45A3
RB1
PIK3C2B
Alt. Freq. in Stemness-low (n=89), %
Alt. Freq. in Stemness-high (n=89), %
F
Alt. Freq. (%)
AR
ERG
TMPRSS2
NCOR1
NCOR2
FOXA1
SPOP
ATM
ATR
BRCA2
CDK12
FANCD2
RAD51B
RAD51C
MLH1
MSH2
PTEN
PIK3CA
PIK3CB
PIK3R1
TP53
RB1
CDKN1B
KMT2C
KMT2D
MYC
AR and signaling
DNA Repair
PI3K and mTOR
Others
UnTx Pri-PCa (Pan-Cancer 2018)
Stemness-low (141)
Stemness-high (141)
mCRPC (SU2C 2019)
Stemness-low (89)
Stemness-high (89)

Figure 6

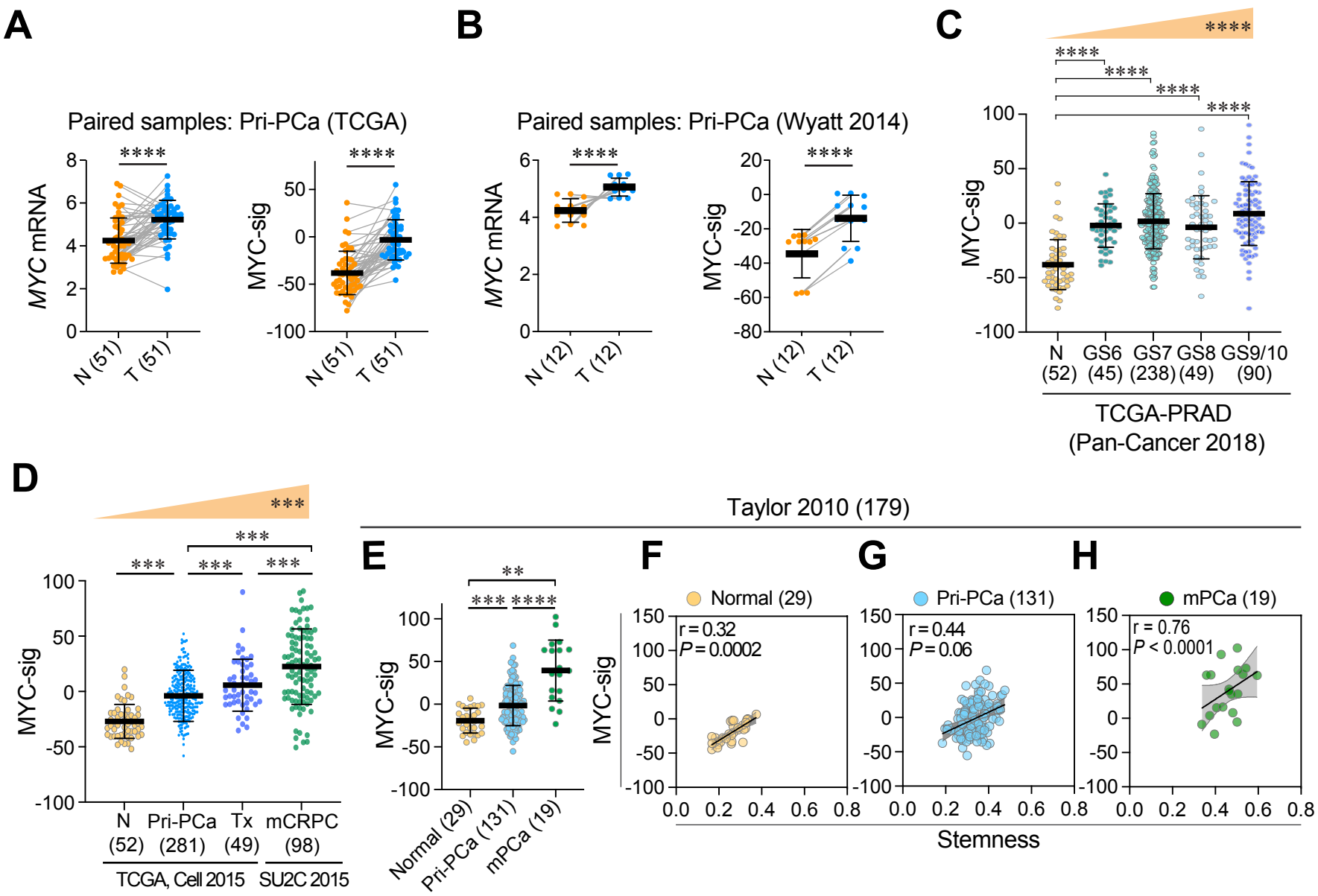

A
Paired samples: Pri-PCa (TCGA)
MYC mRNA
MYC-sig
****
N (51)
T (51)
B
Paired samples: Pri-PCa (Wyatt 2014)
MYC mRNA
MYC-sig
****
N (12)
T (12)
C
MYC-sig
****
N (52)
GS6 (45)
GS7 (238)
GS8 (49)
GS9/10 (90)
TCGA-PRAD
(Pan-Cancer 2018)
D
MYC-sig
***
N (52)
Pri-PCa (281)
Tx (49)
mCRPC (98)
TCGA, Cell 2015
SU2C 2015
Taylor 2010 (179)
E
MYC-sig
**
***
****
Normal (29)
Pri-PCa (131)
mPCa (19)
F
Normal (29)
r = 0.32
P = 0.0002
G
Pri-PCa (131)
r = 0.44
P = 0.06
H
mPCa (19)
r = 0.76
P < 0.0001
MYC-sig
Stemness

Figure 7

Supplementary Information Content

Increasing Stemness Drives Prostate Cancer Progression, Plasticity, Therapy Resistance and Poor Patient Survival

Liu X, Cortes E, et al.

Supplementary Table S1. Summary of datasets used in this study
Supplementary Table S2. Summary of gene signatures used in this study
Supplementary Table S3. DEGs identified in Stemness-high versus Stemness-low subgroups in the Pri-PCa (TCGAPRAD) cohort and in the mCRPC (SU2C 2019) cohort (*six sheets)
Supplementary Table S4. Summary of statistical significance of differences using Tukey's multiple comparisons test (*three sheets)
Supplementary Table S5. Summary of gene signatures and gene sets used in Gene Set Enrichment Analysis

Related to Fig. 1
Supplementary Fig. S1. Schematic illustration of bioinformatic datasets and signature score pipelines used for comparisons across the spectrum of PCa evolution.
Supplementary Fig. S2. Transcriptome-based signature scores for canonical (pro-differentiation) AR signaling activity (AR-A).
Supplementary Fig. S3. Prostate luminal cell compartment harbors higher AR-A but lower Stemness as compared to prostate basal cell compartment.

Supplementary Fig. S4. nADT decreases both AR-A and Stemness.

Related to Fig. 3
Supplementary Fig. S5. Increased Stemness represents a 'universal' feature of PCa progression and aggressiveness.

Related to Fig. 4
Supplementary Fig. S6. High Stemness correlates with poor patient survival.

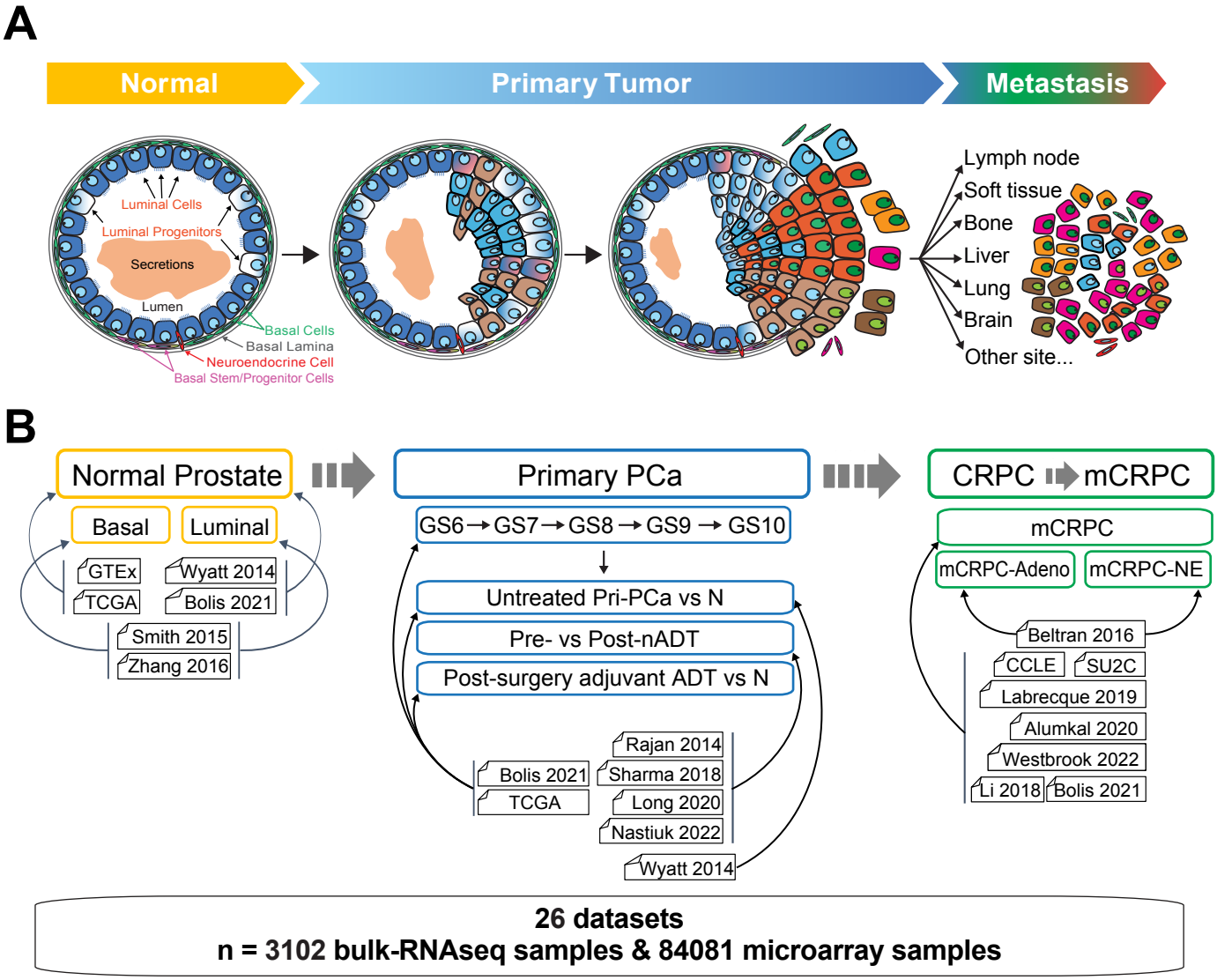
Related to Fig. 5
Supplementary Fig. S7. PCa-Stem signature and gene expression correlate with PCa progression.

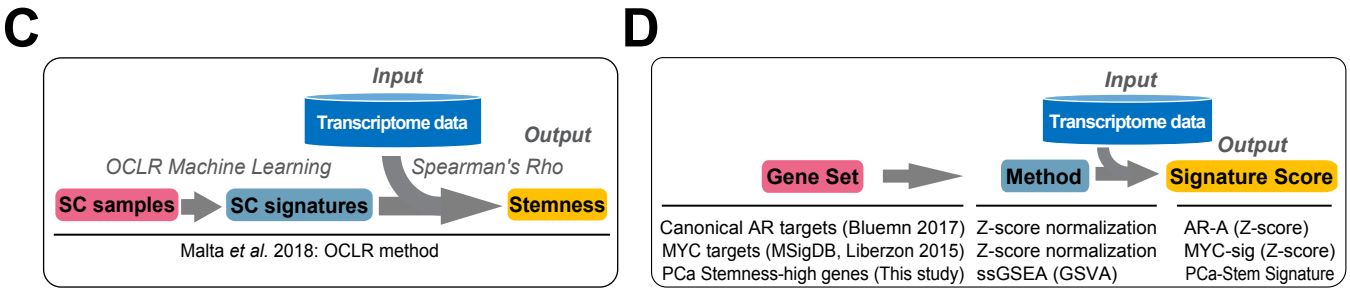
Related to Fig. 6
Supplementary Fig. S8. Unique genomic features of Stemness-high PCa.

Related to Fig. 7
Supplementary Fig. S9. Lack of effect of nADT on MYC activity.

Supplementary Fig. S10. Schematic summary of PCa progression and aggressiveness accompanied by gain of oncogenic Stemness and loss of prostatic epithelium differentiation defined by canonical AR signaling.

Supplementary Figure S1





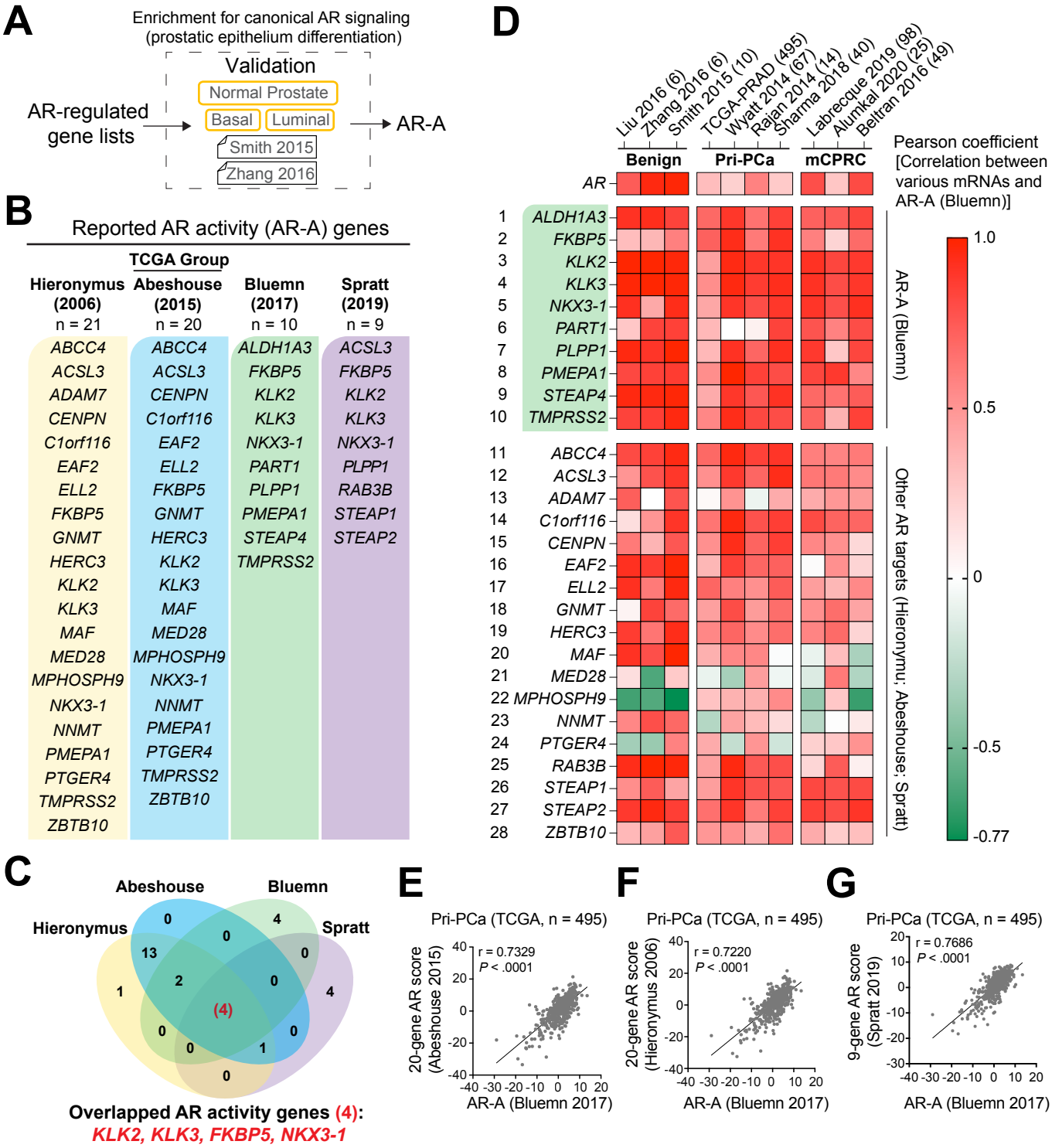
Supplementary Figure S1. Schematic illustration of bioinformatic datasets and signature score pipelines used for comparisons across the spectrum of PCa evolution.

(A-B) Schematic illustrating the spectrum of PCa development, therapy resistance, and metastatic progression (A), and related datasets used for comparisons in different contexts (B). Panel A illustrates the PCa progression continuum from Normal Prostate (Normal) through Primary PCa (Pri-PCa), to Castration-Resistant PCa (CRPC) and Metastatic CRPC (mCRPC), with each stage marked by specific changes in cellular composition and architectural organization. Panel B details the datasets utilized for comparative analyses across these stages, with arrows indicating the relationship of each dataset to specific PCa stages. In total, 26 datasets were used in the current analysis, including 3102 bulk-RNAseq samples and 84081microarray samples. See Supplementary Table S1 for dataset details. (A is adapted from ref. 7).

Detailed Description of PCa Stages:

- Normal Prostate: Depicted as a glandular organ with a pseudostratified two-layer epithelium consisting of basal and luminal cells, interspersed with rare neuroendocrine cells. Luminal cells express cytokeratins CK8 and CK18, androgen receptor (AR), and prostate-specific antigen (PSA), and represent the primary secretory cells. Also depicted are rare luminal progenitor cells within the luminal cell layer, which represent less than 2 % of the luminal cell population and are characterized by the co-expression of CK5 and CK8 and a low level of CD38 (reviewed in ref. 8). Basal cells express CK5 and CK14, interfacing with the stroma through the basal lamina. The basal cell compartment harbors stem/progenitor cells capable of bidirectional differentiation (ref. 8). Also see an enlarged depiction of a normal human prostatic gland in Supplementary Fig. S3A.
- Localized Pri-PCa: Progresses from well-differentiated structures (low Gleason score) to poorly differentiated configurations (high Gleason score), indicating a shift towards a more stem-like state with loss of glandular architecture. This transition involves a reduction in basal cells and an expansion of progenitor-like cells, with the combined Gleason score (GS) reflecting the architectural patterns of cancerous glands. Gleason pattern 1 represents the most well-differentiated glandular structures and Gleason pattern 5 consists of the most poorly differentiated cells lacking glandular structures. Given that PCa is often multifocal, the combined GS is the sum of the two most prevalent patterns, with GS ≤ 7 representing low-grade PCa and GS ≥ 8 representing high-grade PCa. Illustrated here are two representative tumor glands with a decrease/loss in basal cells and expansion of luminal progenitor-like cells.
- Metastatic CRPC: Features increased cellular heterogeneity and the presence of cells with stem-like and neuroendocrine-like characteristics, which drive therapy resistance and disease progression.

(C-D) Schematic presentation of transcriptome-based stemness quantification method mRNAsi (C, ref. 6), and transcriptome-based signature scores for canonical AR signaling activity levels, MYC signaling activity levels and PCa-Stem signature (D). See Supplementary Table S2 for gene signature information.



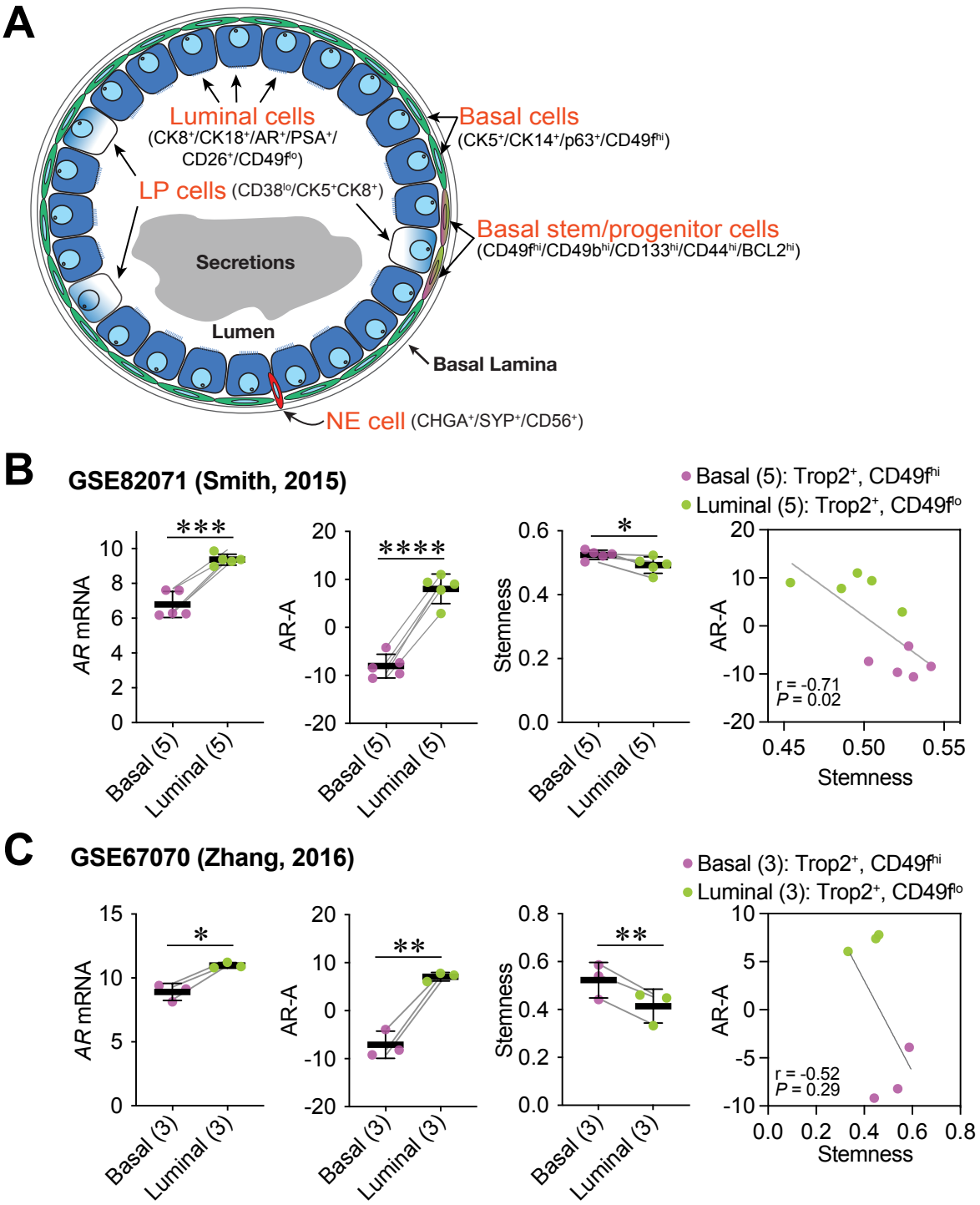
Supplementary Figure S2. Transcriptome-based signature scores for canonical (pro-differentiation) AR-A.

(A) Workflow for validating canonical AR signaling activity (AR-A) signatures from different AR-regulated gene lists.

(B-C) Comparison of AR downstream signaling targets from four studies. The 4 genes commonly shared in all four AR-A signatures are highlighted (C). Genes were listed using updated HGNC symbols (the HUGO gene nomenclature from the Human Genome Organization). Note that in the original publications, some AR-A genes were denoted by their (gene/protein) aliases, as exemplified by *CENPN (BM039), C1orf116 (SARG), KLK3 (PSA), PLPP1 (PPAP2A), and PMEPA1 (TMEPAI)*.

(D) AR-A signature score highly correlates with mRNA expression levels of canonical AR signaling targets in various PCa related cohorts. See Supplementary Table S1 for dataset details.

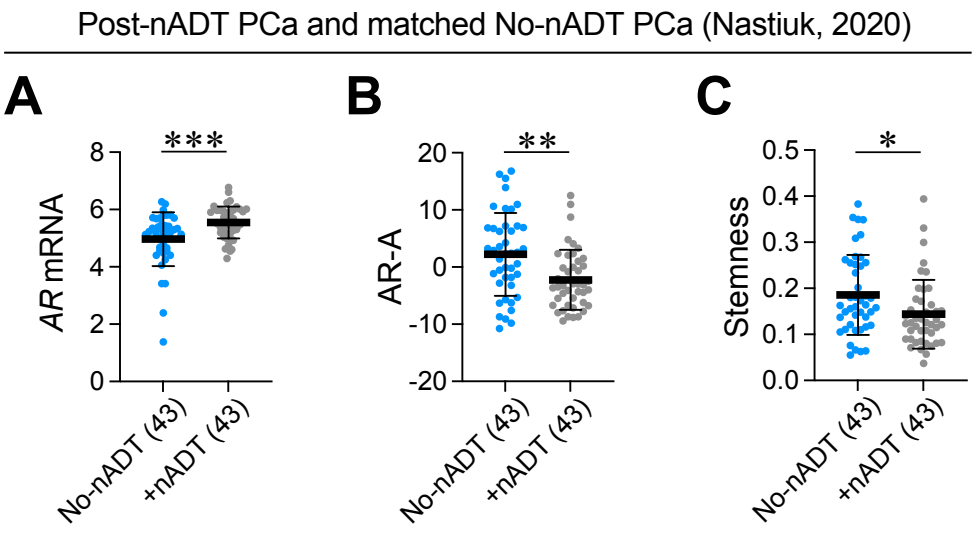
(E-G) Strong positive linear relationships between the Bluemn AR-A and the other three AR-A signatures (Hieronymus 2006; Abeshouse 2015, Spratt 2019) using primary PCa cohort (TCGA-PRAD). r indicates Pearson correlation coefficient.



Supplementary Figure S3. Prostate luminal cell compartment harbors higher AR-A but lower Stemness as compared to prostate basal cell compartment.

(A) Depiction of the major cell types in human prostatic glands. Both basal and luminal cell compartments harbor differentiated as well as less mature stem/progenitor cells. LP, luminal progenitor; NE, neuroendocrine. Cellular markers are highlighted for different cell types. Adapted from ref. 8.

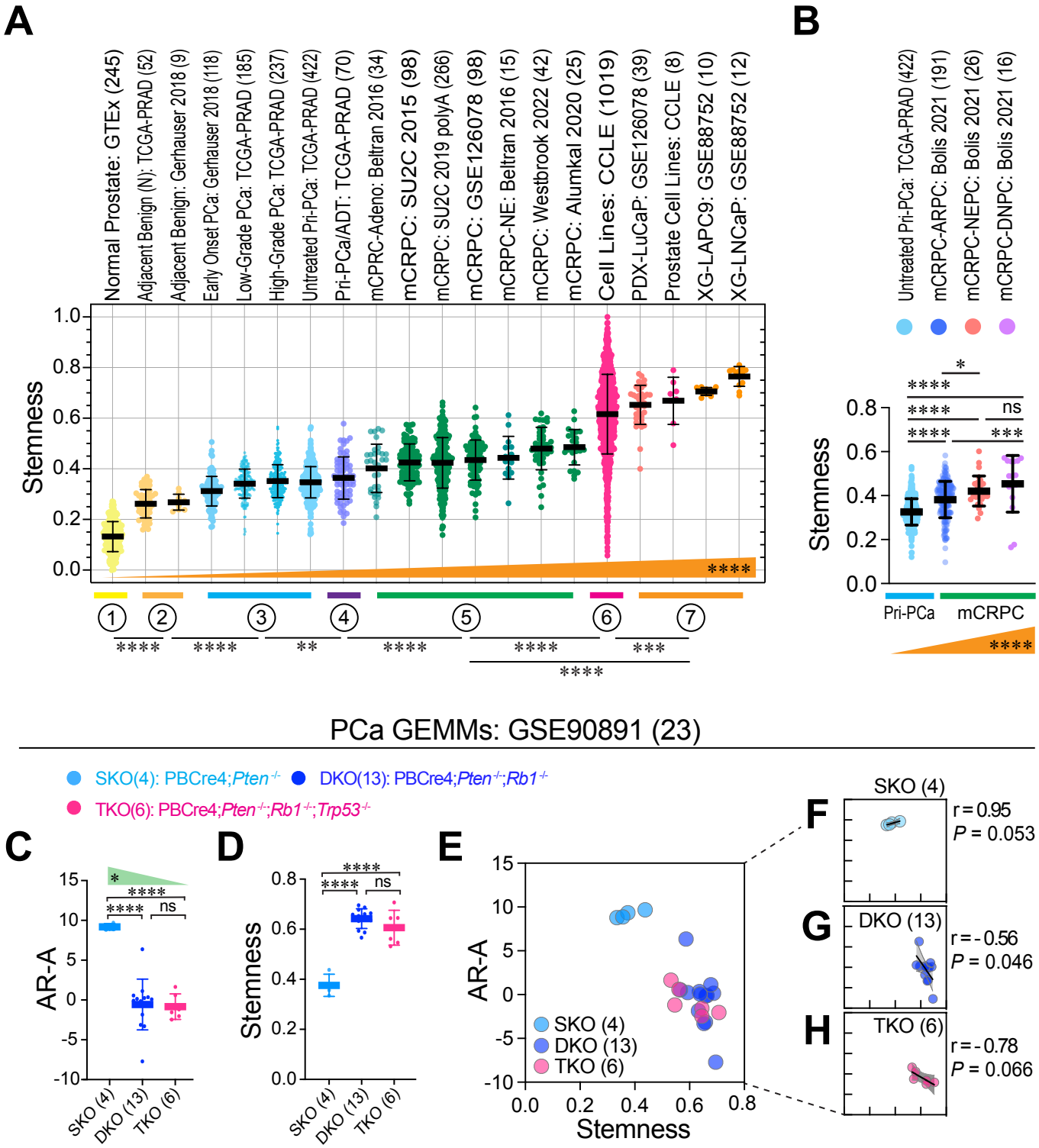
(B-C) Prostate luminal cells possess higher AR-A but lower Stemness as compared to prostate basal cells, and Stemness inversely correlates with AR-A in the context of prostatic basal and luminal cells. Results are shown as mean ± SD. The pairs are linked with a grey line. Significance was calculated by two-tailed paired Student's *t*-test (*, $P < 0.05$; **, $P < 0.01$; ***, $P < 0.001$; ****, $P < 0.0001$). Pearson correlation coefficients (Pearson's r) were used to calculate the correlations between Stemness and AR-A.



Supplementary Figure S4. nADT decreases both AR-A and Stemness.

Matched comparison of *AR* mRNA levels (A), AR-A (B), and Stemness (C) showing significant decrease of both AR-A and Stemness in neo-adjuvant ADT (+nADT) group as compared to the samples without nADT (No-nADT) from stage-, tumor grade-, age-matched PCa individuals (RPCI Nastiuk cohort). Sample sizes are indicated. See Supplementary Table S1 for cohort and RNAseq data information. Within the plots, results are shown as the mean ± SD. Significance was calculated by two-tailed unpaired Student's *t*-test (*, $P < 0.05$; **, $P < 0.01$; ***, $P < 0.001$).

Supplementary Figure S5



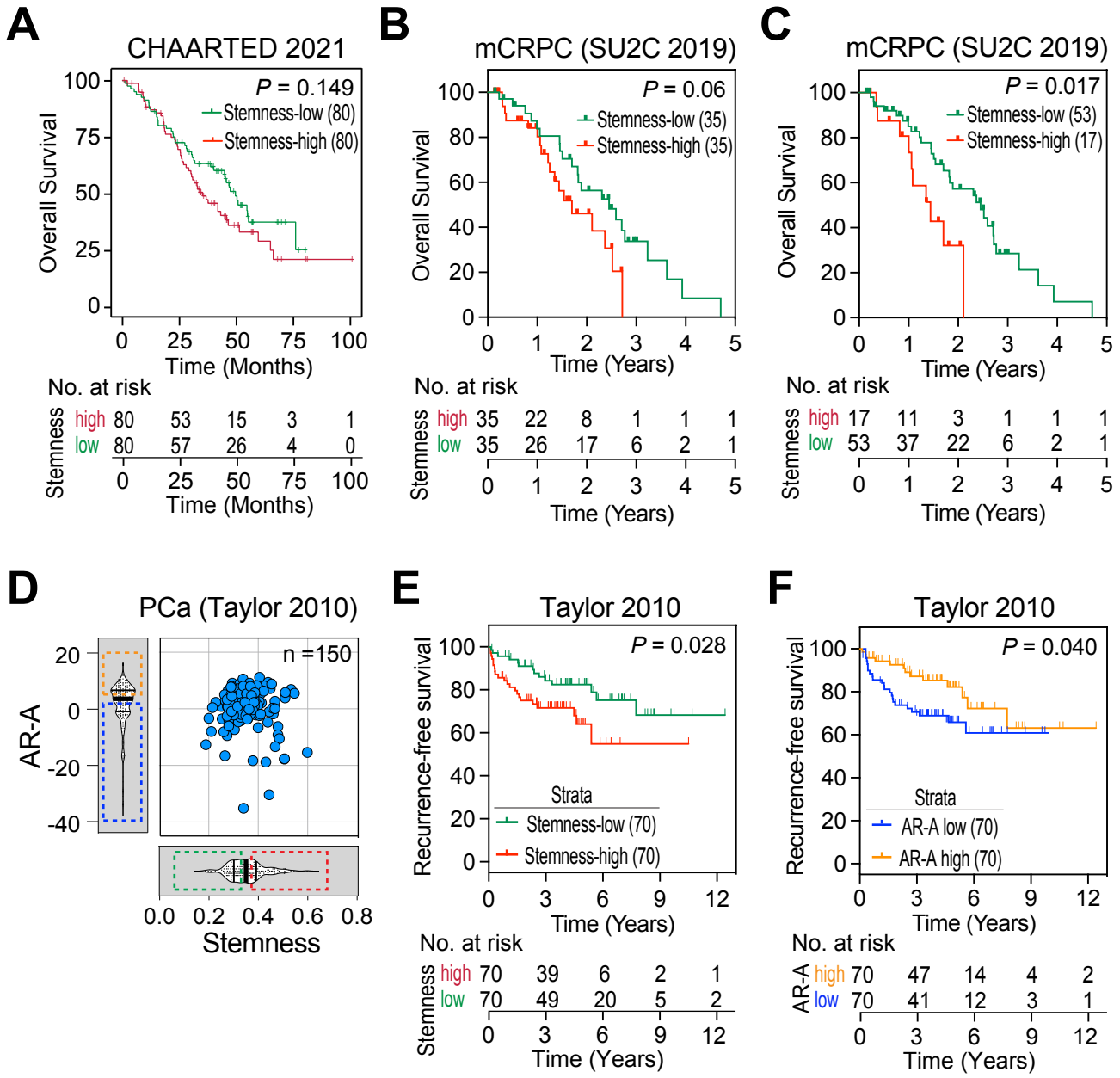
Supplementary Figure S5. **Increased Stemness represents a 'universal' feature of PCa progression and aggressiveness.**

(A) Increasing Stemness accompanies PCa progression and aggressiveness. Stemness scores were shown in various PCa cohorts representing the PCa evolutionary spectrum (from top to bottom): GTEx normal prostate → TCGA tumor-adjacent benign prostate tissue → Treatment-naïve Pri-PCa → aggressive Pri-PCa treated with adjuvant hormone therapy Pri-PCa/ADT → Treatment-failed CRPC → mCRPC → Long-term PCa models including PDX, xenografts (XG) and cell lines. Sample sizes (n) are indicated in the last parentheses. See Supplementary Table S1 for dataset details and Supplementary Table S4 for the statistical significance between different groups.

(B) Progressive increase in Stemness from primary PCa to advanced mCRPC subtypes. This violin plot displays increasing Stemness scores across four PCa groups, defined by treatment status and pathway activity: treatment-naïve Pri-PCa from TCGA, and three subtypes of mCRPC categorized by AR and NE pathway activities - AR pathway-active (ARPC), neuroendocrine (NEPC), and double-negative (DNPC). These three subtypes were delineated based on established signatures (Bluemn *et al.*, 2017, ref. 14; Labrecque *et al.,* 2019, ref. 33). Displayed from left to right are: Untreated Pri-PCa (n = 422), mCRPC-ARPC (191), mCRPC-NEPC (26), and mCRPC-DNPC (16). Pri-PCa samples originated from TCGA, while mCRPC samples were derived from studies by Sharp *et al.* (2019, ref. 67, GSE118435), Labrecque *et al.* (2019, ref. 33, GSE126078), Nyquist *et al.* (2020, ref. 68, GSE147250), Lim *et al.* (2021, ref. 70, GSE171729), and Beltran *et al.* (2016, ref. 28, PRJNA282856; dbGaP: phs000909). Normalized RNAseq data were sourced from the Bolis 2021 integrated cohort (ref. 27). For dataset details, see Supplementary Table S1.

(C-H) PCa progression in GEMMs is characterized by decreasing AR-A and increasing Stemness in aggressive DKO and TKO tumors. The Stemness and AR-A were analyzed in distinct genetically engineering mouse models (GEMMs) of PCa due to individual or combined deletion of 3 tumor suppressor genes, *Pten*, *Rb1* and *Trp53* (Ku *et al*., 2017, ref. 37). Briefly, *Pten*$^{-/-}$ single knockout (SKO) prostate tumors develop around 9 weeks, and mice rarely develop metastasis with a median lifespan of 48 weeks. In contrast, the *Pten*$^{-/-}$;*Rb1*$^{-/-}$ double knockout (DKO) mice develop highly metastatic PCa that shortens median survival to ~38 weeks. DKO tumors are initially castration-sensitive but eventually become castration-resistant and, notably, castration-resistant DKO tumors turn into an AR$^{-/lo}$ phenotype. When *Trp53* is further deleted in DKO background, the triple KO (TKO; *Pten*$^{-/-}$;*Rb1*$^{-/-}$;*Trp53*$^{-/-}$) tumors are exclusively AR^{-} NEPC and castration-resistant *de novo* with high metastatic rate and lifespan of ~16 weeks. AR-A was dramatically reduced (C) but Stemness was significantly increased (D) in the aggressive DKO and TKO PCa compared to indolent SKO prostate tumors. E-H, Scatter plots illustrating the correlations between AR-A and Stemness in combined cases in PCa GEMMs (E), SKO (F, Pearson's r=0.95, P = 0.053), DKO (G, Pearson's r= –0.56, P = 0.053), and TKO (H, Pearson's r= –0.78, P = 0.066).

All data in dot plots and violin plots are shown as mean ± SD. Statistical significance was determined using one-way analysis of variance (ANOVA) followed by Tukey's multiple-comparison test. Jonckheere-Terpstra's trend (J-T) test was used to calculate the statistical significance of the trend across different groups. Pearson correlation coefficients (Pearson's r) were used to calculate the correlations between the Stemness and AR-A. Note: ns, not significant; *, P < 0.05; **, P < 0.01; ***, P < 0.001; ****, P < 0.0001.

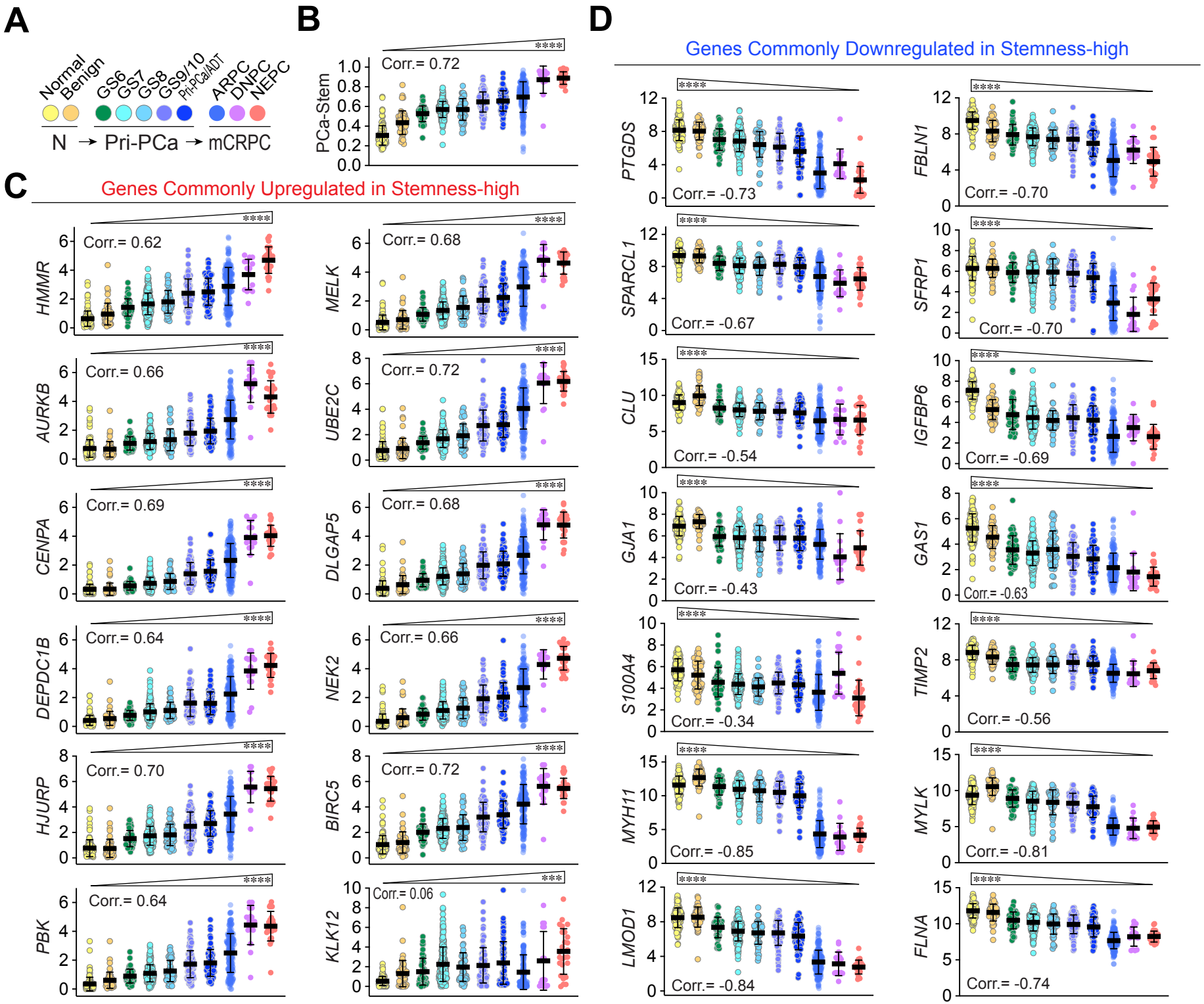


Supplementary Figure S6. High Stemness correlates with poor patient survival.

(A-C) High Stemness correlates with poorer overall survival in CHAARTED 2021 cohort (A) or SU2C mCRPC cohort (B-C). The CHAARTED 2021 cohort was divided into Stemness-high (n = 80) and Stemness-low (n = 80) using Stemness median split (A). The SU2C 2019 mCRPC cohort was divided into Stemness-high and Stemness-low using Stemness median split (B) or the analysis was done by comparing the 25% of highest Stemness samples with the 75% of lowest Stemness samples (C). *P*-value was determined using the Log-Rank test.

(D-F) High Stemness and low AR-A correlate with worse recurrence-free survival in PCa patients in the Taylor 2010 PCa cohort. Stemness (E) or AR-A (F) was used to fractionate Taylor cohort for Kaplan-Meier analysis. The Taylor patient cohort was divided into Stemness-high (n = 70) and Stemness-low (n = 70) using Stemness median split (E) or AR-A high (n = 70) and AR-A low (n =70) using AR-A median split (F) followed by the Kaplan-Meier analyses. Note: there are 150 PCa samples with transcriptome data in the Taylor cohort but only 140 PCa samples with survival data. *P*-value was determined using the Log-Rank test.

Supplementary Figure S7



Supplementary Figure S7. PCa-Stem signature and gene expression correlate with PCa progression.

(A) Schematic of PCa continuum, from normal prostate (N) through various stages of primary PCa (Pri-PCa) to treatment-failed mCRPC. Sample groups include:

- Two subgroups in N (Normal/Benign), including GTEx normal prostate (n=116) and TCGA tumor-adjacent benign prostate tissue (n=52).
- Five subgroups in Pri-PCa, including GS6 (n=45), GS7 (n=238), GS8 (n=49), combined GS9 and GS10 (GS9/10; n=90), and aggressive Pri-PCa treated with post-surgery adjuvant hormone therapy (Pri-PCa/ADT; n=70).
- Three subtypes of mCRPC, including AR-active PCa (ARPC; n=191), double-negative AR-null/neuroendocrine-null PCa (DNPC; n=16), and neuroendocrine PCa (NEPC; n=26).

*Note that the color-coded entities of normal/benign prostate and progressive PCa stages in panel A also represent the legend for all dot plots in panels B-D.

(B) Dot plot showing the increasing 12-gene PCa-Stem signature scores positively correlate with the PCa progression described in (A).

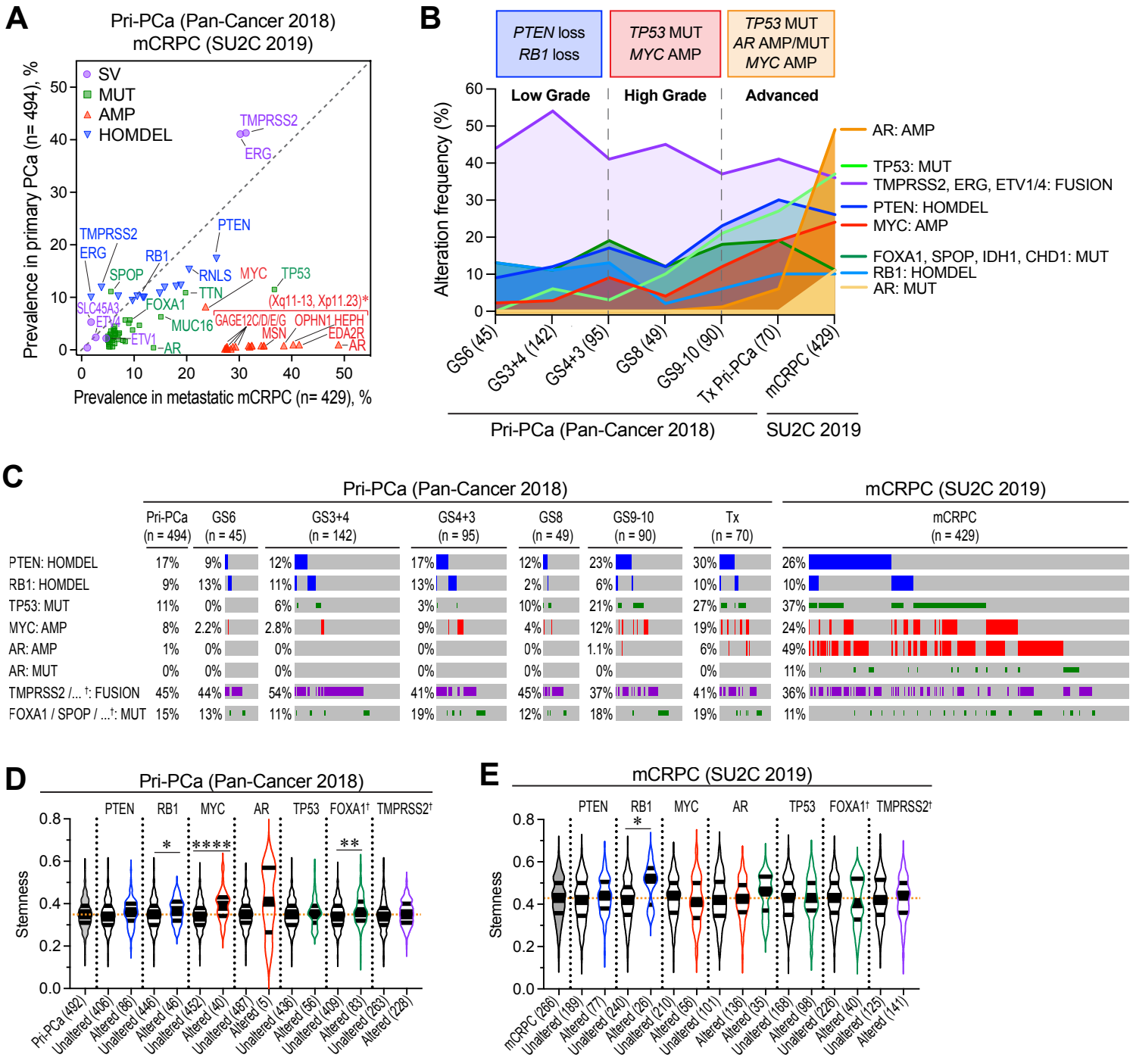
(C) Dot plots showing that the mRNA levels of 11 of the 12 PCa-Stem signature genes (i.e., *HMMR, AURKB, CENPA, DEPDC1B, HJURP, PBK, MELK, UBE2C, DLGAP5, NEK2,* and *BIRC5)* except *KLK12* (see Figure 5D; Supplementary Table S3) exhibited stage-related increases and positively correlated with PCa progression.

(D) Dot plots showing that the mRNA levels for 14 genes commonly downregulated in Stemness-high groups (i.e., *PTGDS, SPARCL1, CLU, GJA1, S100A4, MYH11, LMOD1, FBLN1, SFRP1, IGFBP6, GAS1, TIMP2, MYLK, and FLNA; see* Supplementary Table S3) all individually displayed stage-related downregulation and negatively correlated with PCa progression.

For all dot plots, the Pearson's correlation coefficients (Corr.) are shown for the relationships between PCa progression scores (derived from trajectory inference analysis in the PCa transcriptome atlas; Bolis 2021; ref.27) and either PCa-Stem signature scores (B) or individual gene expression levels (C, D).

Dot plots display the mean ± SD. Trends across groups were assessed using the Jonckheere-Terpstra (J-T) trend test (wedges above). ***, $P < 0.001$; ****, $P < 0.0001$; ns, not significant.

Data Source: Normalized RNA-seq data across the stages (shown in the legend in A) were obtained from the integrated transcriptomic framework of PCa (Bolis 2021; ref.27).



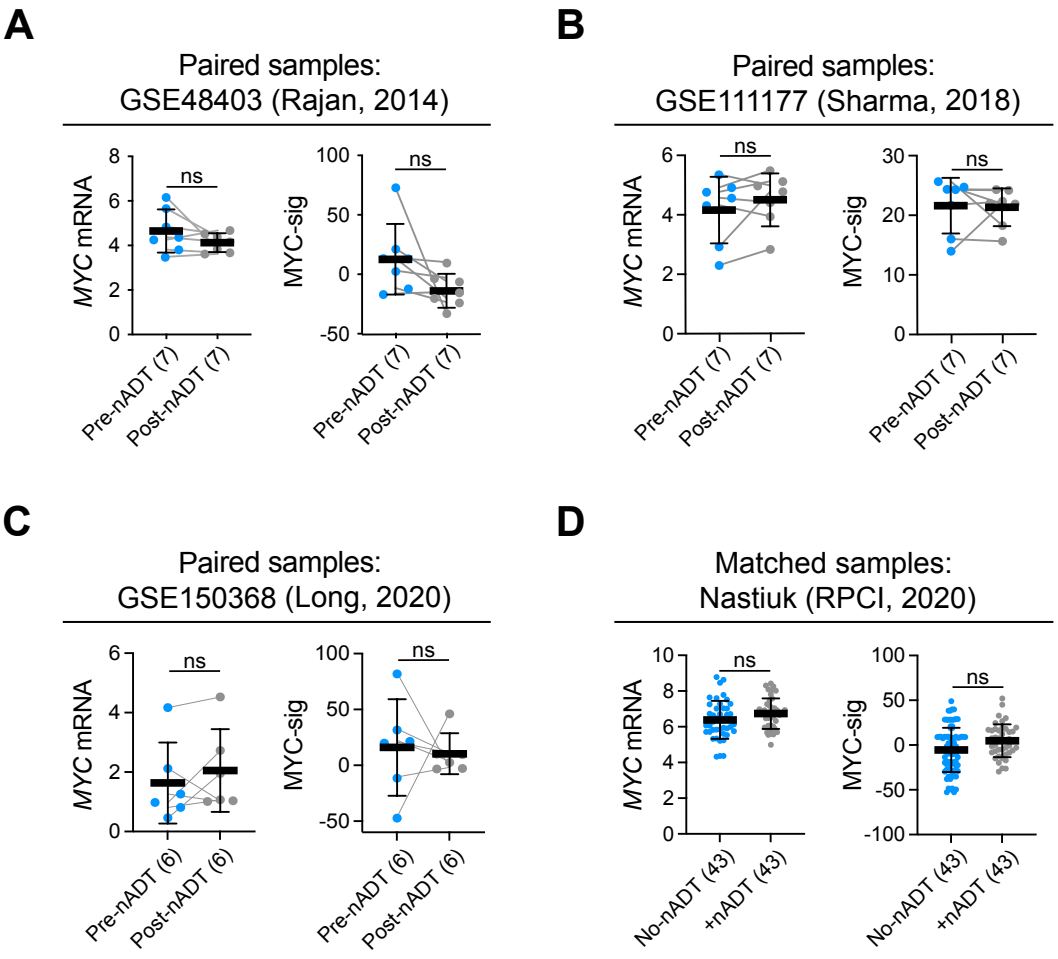
Supplementary Figure S8. Unique genomic features of Stemness-high PCa.

(A) Scatterplot of observed frequencies of genomic alterations in cancer genes reported in Pri-PCa (TCGA) versus mCRPC (SU2C) with data retrieved from cBioPortal. SV (purple), structural variants/fusions; MUT (green), mutation; AMP (red), amplification in DNA copy numbers (i.e., copy number alterations (CNA) ≥ 2); HOMDEL (blue), homozygous deletion or deep deletion.

(B) Genomic alteration frequency plot showing that (early-stage) low-grade PCa have prevalent *PTEN* and *RB1* loss and high-grade PCa have frequent *TP53* MUT and *MYC* AMP whereas advanced PCa have prevalent *TP53* MUT, *MYC* AMP and *AR* AMP/MUT.

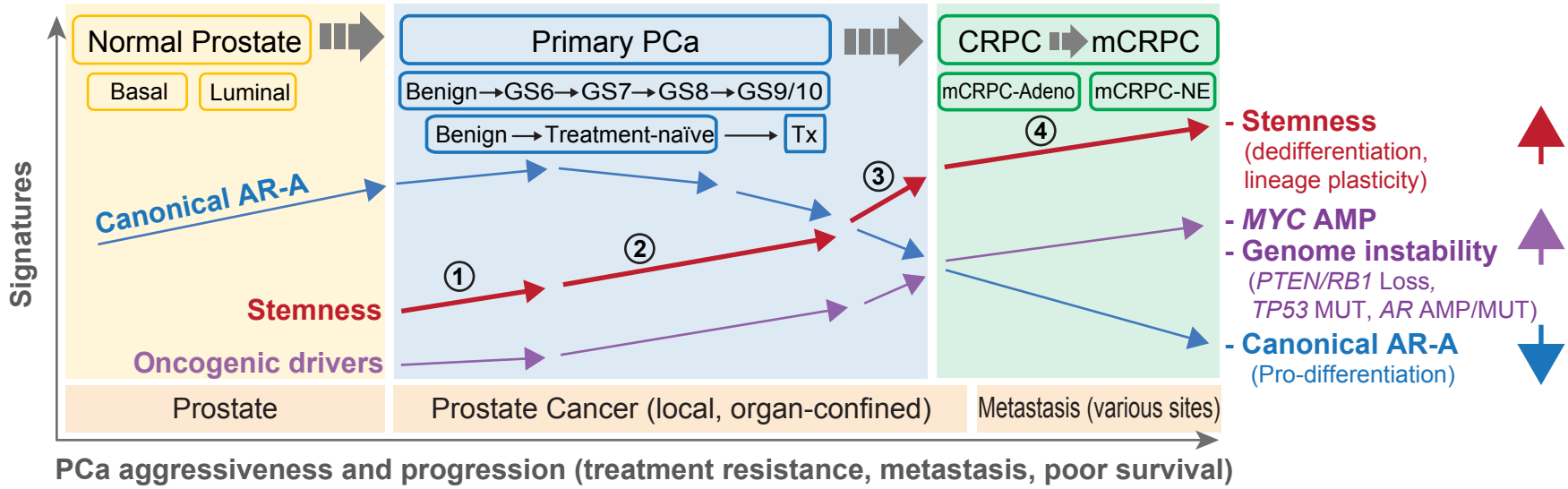
(C) cBioPortal Oncoprint showing the frequencies of major genetic alteration events along the PCa progression continuum.

(D-E) Association of major genomic alterations in PCa with Stemness. Grey, no alterations; Blue, HOMDEL; Green, MUT; Red, AMP; Purple, Fusion. TMPRSS2 /...†: FUSION (in C) or TMPRSS2† (in D-E) stands for combined fusion events in *TMPRSS2*, *ERG*, *ETV1* and *ETV4*; FOXA1 / SPOP /...†: MUT (in C) or FOXA1† (in D-E) represent combined mutation events in *FOXA1*, *SPOP*, *IDH1* and *CHD1*. Note that data presented represent the major mutation subtypes in Pri-PCa (TCGA PRAD cohort) reported in Cancer Genome Atlas Research Network 2015 (Abeshouse *et al.*, 2015, ref. 18) and alterations (mutations, structural variants and copy number) of unknown significance were excluded. Within the violin plots, the center lines represent median values, and box edges are 75th and 25th percentiles. Significance was calculated by Mann-Whitney test (*, $P < 0.05$; **, $P < 0.01$; ****, $P < 0.0001$).



Supplementary Figure S9. Lack of effect of nADT on MYC activity.

Matched comparisons showing no significant differences in both *MYC* mRNA and MYC-sig after neo-adjuvant ADT (Post-nADT) as compared to the matched samples before nADT (Pre-nADT) from the same individuals in **A**, Rajan 2014 cohort; **B**, Sharma 2018 cohort; and **C**, Long 2020 cohort or in **D**, the RPCI Chatta/Nastiuk cohort (unpublished) comprising PCa samples from patients who received nADT (+nADT) and the patients who did not receive ADT (no-ADT) but otherwise matched (with the +nADT patients) for ages and tumor stage and grade.
Sample sizes are indicated in parentheses. Within the plots, results are shown as the mean ± SD. The pairs are linked with a grey line. Significance was calculated by two-tailed paired (A-C) or unpaired (D) Student's *t*-test (ns, not significant; *, $P < 0.05$). See Supplementary Table S2 for MYC-sig gene signature information.



Supplementary Figure S10. Schematic summary of PCa progression and aggressiveness accompanied by gain of oncogenic Stemness and loss of prostatic epithelium differentiation defined by canonical AR signaling.

In the current study, we quantified the oncogenic dedifferentiation state (Stemness; indicated by red arrows) and canonical pro-differentiation AR signaling activity (AR-A; blue arrows) using transcriptomic data (3102 RNA-seq and 84081 microarray samples) collected from 26 datasets encompassing the evolutionary spectrum of PCa development and progression – normal prostate, early-stage and advanced primary tumors, metastatic castration-resistant PCa, and PCa subjected to long-term or neo-adjuvant androgen-deprivation therapy (ADT). Our analysis reveals a continual increase in the Stemness at all PCa progression stages, i.e., (1) PCa initiation and early tumor growth (compared with normal or matched benign prostate tissues); (2) natural tumor progression (treatment-naïve); and (3) long-term ADT to treatment resistance and metastasis. In contrast, the pro-differentiation AR-A displays a bell-shape trajectory with an increase in early-stage tumors followed by steady decreases in advanced tumors and the lowest in mCRPC. Our results also demonstrate that the increased AR-A represents a driving force of elevated Stemness in early PCa but tumor progression is accompanied by a divergence between decreasing AR-A and increasing Stemness, and clinical therapies such as ADT further diversify AR-A and Stemness. In fact, canonical AR-A shows an inverse correlation with the Stemness in treatment-failed mCRPC, and the Stemness tracks faithfully with the treatment-induced reprogramming. On the other hand, akin to the accompanying continually increasing Stemness, PCa progression is characterized by continually elevating *MYC* amplifications and activity, as well as increasing genome instability associated with deletion of tumor suppressors and *AR* amplifications and mutations (indicated by purple arrows). Importantly, high Stemness correlates with poor patient survival suggesting that Stemness is prognostic of patient outcomes, and increased Stemness represents a 'universal' feature of PCa progression and aggressiveness.