

Epigenetic and biomolecular profiling of patient-derived testicular cancer-associated fibroblasts and their reciprocal interaction with germ cell tumors

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Hiermit versichere ich an Eides statt, dass diese Dissertation von mir selbstständig und ohne unzulässige fremde Hilfe unter Beachtung der „Grundsätze zur Sicherung guter wissenschaftlicher Praxis an der Heinrich-Heine-Universität Düsseldorf“ erstellt worden ist. Die Arbeit wurde bisher keiner Prüfungsbehörde vorgelegt und auch noch nicht veröffentlicht. Ich habe bisher keinen erfolglosen Promotionsversuch unternommen.

Düsseldorf, den

Alexa Stephan

‘Just talk yourself up
And tear yourself down
You’ve hit your one wall
Now find a way around’

from ‘For A Pessimist, I’m Pretty Optimistic’
by Paramore

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Abstract

Type II germ cell tumors (GCT), one form of testicular cancer (TC), are one of the most common solid tumors in young men of age 15 - 54. GCTs type II are subdivided into the two main subclasses seminoma (SE) and non-seminoma (NS), which both account for 98 % of all TC diagnoses. NS, with embryonal carcinoma (EC) as a stem cell population, can be further stratified into teratoma (TE), yolk-sac tumors (YST), and choriocarcinoma (CC).

Alterations in the cellular and molecular milieu during the embryogenesis fuel the pathophysiological development of the primordial germ cells (PGCs), the precursor cells of the gametes, giving rise to a germ cell neoplasia in situ (GCNIS), the then precursor lesion of GCTs. Later, the tumor microenvironment (TME) is involved in the plasticity of GCTs, e.g., by reprogramming SE cells into an EC-like cell fate. Non-tumoral cells in the TME, like cancer-associated fibroblasts (CAF) are known to significantly promote tumor growth, therapy resistances, and eventually impair the patient's outcome. In previous studies, the *in vitro* interactions between GCT and TME cells were profiled. Especially the 3D interaction with non-tumoral fibroblasts (nFB) influenced the GCT cells' growth behavior, cisplatin response, and expression of cisplatin sensitivity-related factors suggesting that the crosstalk of TME with GCT cells is crucial for tumor progression and therapy outcome. Changes on transcriptome and secretome level were observed in nFBs following the direct cell-cell contact with GCT cells. Elevated gene expression and signal pathways associated with e.g., extracellular matrix modulation, inflammation, and morphogenesis implied an activation of these stromal cells into a pro-inflammatory and pro-tumoral possible CAF-like cell state.

In this study, patient-derived GCT originating CAFs were comprehensively characterized *ex vivo*. Twelve distinct GCT-CAF cultures were successfully established, and epigenetically and molecularly described by performing DNA methylation arrays, RNA sequencing (RNAseq), and mass spectrometry (MS) -based proteome and secretome analysis. These analyses demonstrated that the activation of CAFs is influenced by the prevailing TME in which they have resided. Hereby, SE and EC potentially sustain / support the CAF activation state, whereas TE play only a minor role in CAF formation. By correlating the high throughput data of the DNA methylome, transcriptome, proteome, and secretome, novel factors in the GCT-related TME were identified being significantly hypomethylated, upregulated and secreted in and by the CAF populations. The identified effector molecules IGFBP1, LGALS3BP, and LYVE1 influenced the proliferation and gene expression of cisplatin sensitivity-related factors in GCT cells lines. The data of this thesis suggests a reciprocal interaction between CAF and GCT cells, whereby GCTs influence the CAF's activation state while CAFs affect the tumor growth and cisplatin response. The novel targets IGFBP1, LGALS3BP, and LYVE1 potentially serve as future prognostic or diagnostic markers and as foundation for potential therapeutical interference with CAFs in the GCT context.

Zusammenfassung

Keimzelltumoren vom Typ II, eine Form von Hodenkrebs, sind einer der häufigsten soliden Tumoren bei jungen Männern im Alter von 15 bis 54 Jahren. Keimzelltumoren Typ II werden in die beiden Hauptklassen Seminome und Nichtseminome unterteilt, die zusammen 98 % aller Hodenkrebs-Diagnosen ausmachen. Nichtseminome, mit dem embryonalen Karzinom als Stammzellpopulation, können weiter in Teratome, Dottersacktumoren und Chorionkarzinome stratifiziert werden.

Veränderungen in dem zellulären und molekularen Milieu während der Embryogenese begünstigen die pathophysiologische Entwicklung der primordialen Keimzellen, die Vorläuferzellen der Geschlechtszellen, und führen zu der Entstehung einer Keimzellneoplasie *in situ*, der Vorläuferläsion von Keimzelltumoren. Später ist die Tumormikroumgebung maßgeblich an der Plastizität von Keimzelltumoren beteiligt, z. B. durch die Reprogrammierung von Seminom-Zellen in ein embryonales Karzinom-ähnliches Zellschicksal. Darüber hinaus ist bekannt, dass nicht-tumorale Zellen in der Tumormikroumgebung, wie z. B. krebsassoziierte Fibroblasten, das Tumorwachstum und die Therapieresistenz erheblich fördern und schließlich die Behandlungsergebnisse des Patienten beeinträchtigen. In früheren Studien wurden die *in vitro*-Interaktionen zwischen Keimzelltumor- und Tumormikroumgebung-Zellen beschrieben. Dabei beeinflusste insbesondere die 3D-Interaktion mit nicht-tumoralen Fibroblasten das Wachstumsverhalten, das Ansprechen auf Cisplatin und die Expression von Cisplatin-Sensitivitäts-bezogenen Faktoren in Keimzelltumor-Zellen, was darauf hindeutete, dass die gegenseitige Beeinflussung zwischen der Tumormikroumgebung und Keimzelltumor-Zellen für die Tumorprogression und das Therapieergebnis entscheidend ist. In nicht-tumoralen Fibroblasten wurden nach dem direkten Zell-Zell-Kontakt mit Keimzelltumor-Zellen Veränderungen auf Transkriptom- und Sekretom-Ebene beobachtet. Erhöhte Genexpression und induzierte Signalwege, die z. B. mit der Modulation der extrazellulären Matrix, Inflammation und Morphogenese in Verbindung stehen, deuteten auf eine Aktivierung dieser Stromazellen in einen pro-inflammatorischen und pro-tumoralen, möglicherweise CAF-ähnlichen Zellzustand hin.

In dieser Studie wurden von Keimzelltumor-Patienten stammende Krebs-assoziierte Fibroblasten umfassend *ex vivo* charakterisiert. Zwölf verschiedene Krebs-assoziierte Fibroblasten-Kulturen wurden erfolgreich etabliert und epigenetisch und molekular beschrieben, indem DNA-Methylierungs-Arrays, RNA-Sequenzierungen und Massenspektrometrie basierte Proteom- und Sekretomanalysen durchgeführt wurden. Diese Analysen zeigten, dass die Aktivierung von Krebs-assoziierten Fibroblasten von der vorherrschenden Tumormikroumgebung beeinflusst wurde, in der sie sich zuvor befanden. Dabei können Seminome und embryonale Karzinome den Aktivierungszustand potenziell

aufrechterhalten / unterstützen, während Teratome nur eine geringe Rolle bei der Aktivierung spielen. Durch die Korrelation der Hochdurchsatzdaten des DNA Methyloms, Transkriptoms, Proteoms und Sekretoms wurden neue Faktoren in der Keimzelltumor-bezogenen Tumormikroumgebung identifiziert, die in den Krebs-assoziierten Fibroblasten-Populationen signifikant hypomethyliert, hochreguliert und sezerniert waren. Die identifizierten Effektormoleküle IGFBP1, LGALS3BP und LYVE1 beeinflussten die Proliferation und Genexpression von Cisplatin-Sensitivitäts-bezogenen Faktoren in Keimzelltumor-Zelllinien.

Die Daten dieser Arbeit deuten auf eine wechselseitige Interaktion zwischen Krebs-assoziierten Fibroblasten und Keimzelltumor-Zellen hin, wobei Keimzelltumoren den Aktivierungszustand der Krebs-assoziierten Fibroblasten beeinflussen, während Krebs-assoziierten Fibroblasten das Tumorwachstum und die Reaktion auf Cisplatin beeinflussen. Die neuen Zielmoleküle IGFBP1, LGALS3BP und LYVE1 können potenziell als zukünftige prognostische oder diagnostische Marker und als Grundlage eines möglichen therapeutischen Ansatzes in Keimzelltumoren dienen.

1 Introduction

This study provides an insight into the tumor microenvironment (TME) of testicular cancer (TC). We characterized cancer-associated fibroblasts (CAFs), an environmental cell type, which is known to play a crucial role in the tumor progression, development of drug resistances and consequently the patient's clinical outcome in other cancers. For the first time in TC, CAFs were comprehensively described by comparing fibroblasts (FBs) derived *ex vivo* from patients with the most common testicular germ cell tumor (GCT) subtypes – seminoma (SE) and non-seminoma (NS). The molecular depiction of testicular GCT-derived CAFs was further used to decipher their reverse influence on GCT cell lines *in vitro*. Henceforth, it is fundamental to understand the pathogenesis of testicular GCT, on the one part, and the development of CAFs and their role in drug resistance, on the other part. Therefore, the following sections will give an inclusive picture of these two main topics (TC: **chapter 1.1**; CAF: **chapter 1.2**).

1.1 Testicular cancer: germ cell tumors type II

1.1.1 The epidemiology

TC is one of the most common cancer types in men between the age of 15 - 54 years (**Figure 1a**) [2–4]. The incidence rate, meaning the number of diagnosis independent of mortality, is usually indicated as the age standardized rate (ASR) to normalize the different age distributions in the individual countries. The highest ASR was observed in Western Europe (9.3 / 100'000) in comparison to rather low numbers in other regions like Northern Africa (0.59 / 100'000) (**Figure 1b**, upper panel) [5]. Over the past decades, the incidence of TC has constantly risen worldwide with a total of 74'458 new cases in 2020 (**Figure 1c**) [5]. Estimations for European countries predicted an overall growth of 13 % in diagnoses by 2035 [6]. On behalf of Germany, the estimated ASR for 2035 therefore exceeded the previous rate (9.1 / 100'000, 2010) with 11.5 new diagnosis per 100'000 standard population conveying Germany into the top three countries with the highest estimated incidence rates of Europe [6].

Testicular GCTs, a type of TC, is a type of cancer that has been affecting most commonly young men. For instance, in Germany, the median age at diagnosis for GCTs is 37 years [7]. Moreover, the age of diagnosis varies when considering the two most prevalent GCT subtypes – SE and NS (see **chapter 1.1.3** for further details on the subtypes). In North-Rhine Westphalia, the age-specific peak for the diagnosis has then been around the age of 25 years for NS, while being the age of 35 years for SE [8]. As NS and SE accounted for over 98 % of all TC diagnosis in Germany between 2008 and 2016 this affects men in the middle of their lives [8].

Mostly non-Hispanic white men were diagnosed with TC [9]. This is argued by the hypothesis that black men have different testosterone levels, which in fact is not true as non-Hispanic black men only have higher estradiol but not testosterone levels [10]. Admittedly, the highest incidence rates, but also the best survival rates emerged in non-Hispanic white men [9]. Ongoing efforts to improve cancer screening and treatment, access to a sophisticated healthcare system, environmental and dietary factors may explain the paradigm of high incidence but low mortality in high income countries or countries with a high 'human development index' (HDI), such as Germany (**Figure 1d**) [11].

Globally, the TC mortality has been stable in the last 20 years, but the age standardized death rate (ASDR) slightly decreased in higher income countries (**Figure 1d**) [12]. In 2019, according to the *Robert-Koch-Institut*, a total of 158 TC-related deaths occurred in Germany [7]. In comparison, the highest mortality rates occurred in Central and South America, Eastern and Southern Europe, and Western and Southern Africa (**Figure 1b**, lower panel) [13]. However, this disease is not only predominantly diagnosed in young men, but also most of the disease-related deaths occurred in men between 15 to 49 years of age [12].

In 95 % of all TC diagnosis, the primary tumors are manifested in the gonads but only 1 % are presented bilateral [14–17]. In rare cases, the primary tumor can be found extragonadal along the body midline in the retroperitoneum (30 - 40 %), mediastinum (50 - 70 %) or cranial (1 %) (**Figure 1e**) [14,18].

Nonetheless, TC has been used as a prime example of the curability of cancer. The success of cancer treatment is often described using the 5-year overall survival (OS) rate, which represents the proportion of patients who are still alive 5 years after their initial diagnosis. For instance, in Germany, TC diseased patients had the highest OS (93 - 97 %) compared to other cancers [19,20]. But cancer treatment ultimately leads to short- and long-term side effects like impaired reproductive health and higher risks to develop secondary solid cancers and leukemia [21]. Further, the 2-year OS for treatment resistant (refractory) patients drops to 37 % [22]. To change these devastating prospects for young men with TC, it is critical to understand and prevent potential risk factors for this cancer type. According to Znaor et al., the predicted increase in incidence rates, as mentioned earlier, were also attributed to changes in risk factors in the upcoming years [6]. Therefore, the next chapter elucidates the etiology of TC.

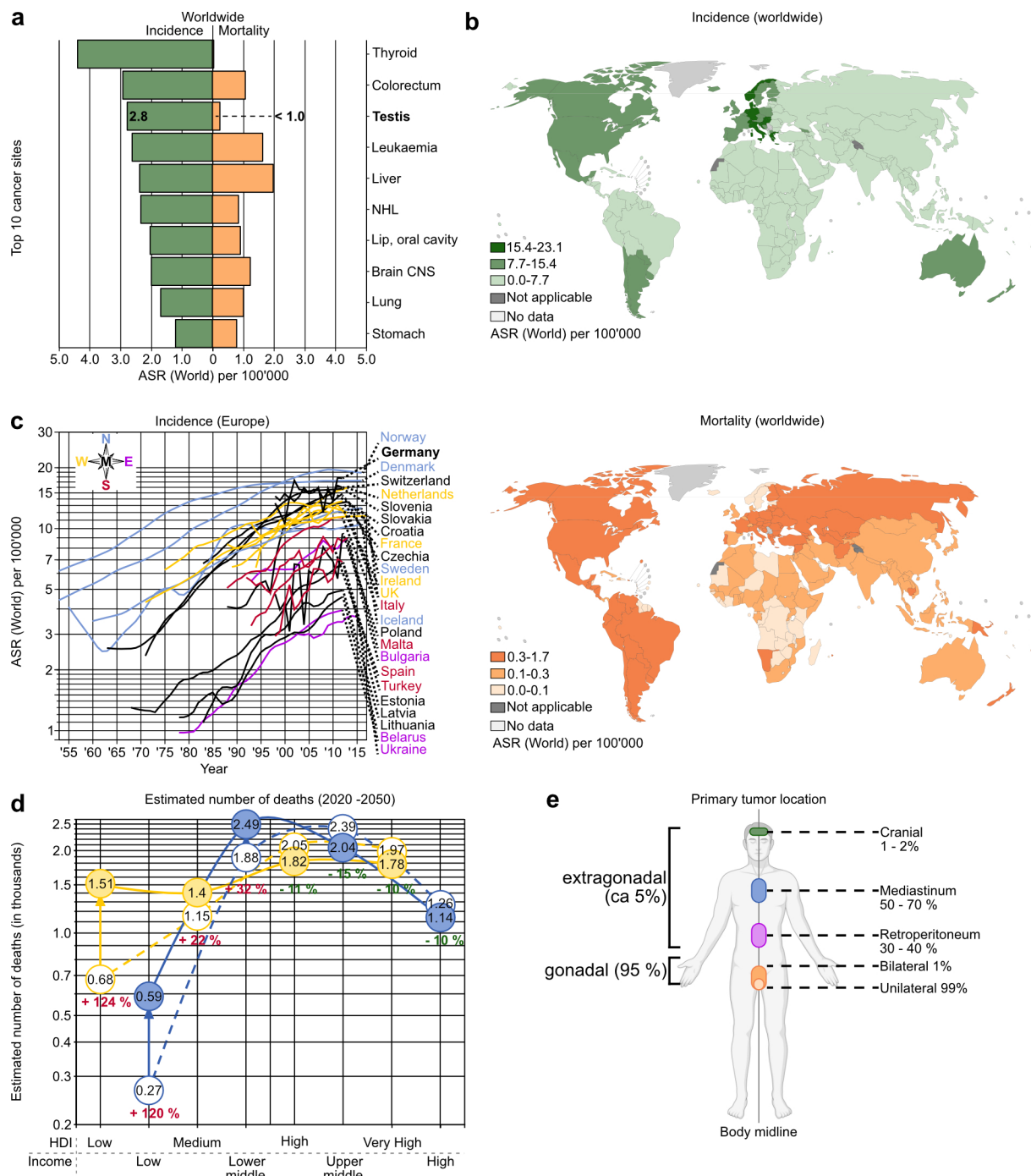


Figure 1: TC epidemiology.

Cancer burden in males between the ages of 15 and 54 years, ASR per 100'000 standard population, data state from 2022: Present incidence and mortality rates ranking the top 10 cancer entities (a), and showing TC globally (b). (c) Incidence rates of TC in Europe over time (UK divided into Scotland, England and Wales, and North Ireland independently). (d) TC-related deaths present (2020) and estimated (2050) based on the HDI and the income. (e) Anatomically site of primary tumor location. a - d created with the global cancer statistic tool GLOBOCAN by the WHO (gco.iarc.fr) [2]. Illustrations of e partially created with BioRender.com by Alexa Stephan. ASR: Age-standardized rate; HDI: Human development index; NHL: Non-Hodgkin-Lymphoma; CNS: Central nervous system.

1.1.2 The etiology: risk factors for tumor development

The leading cause for TC has not yet been determined because the involvement of one main driver mutation is still unknown. One shallow and commonly used explanation for TC has been the industrialization and westernized lifestyle. Considering the elevated incidence rates in western countries, and a study of non-European immigrants showing lower incidence rates than the non-immigrated population, supports this theory [5,23]. As expected, the answer is more complex and it appears to be an interaction between genetic alteration, environment influences, and hormonal disruption [24]. Even though the certain cause for TC is still unclear, several potential risk factors have been proposed.

The most prominent and recognized risk factors have been physiology changes of the testis – the testicular dysgenesis syndrome (TDS), and, partially caused by this, (reduced) infertility. The global fertility, or rather the fecundity referring to the plain biological capability to reproduce, is postulated to have declined in the recent decades and interestingly the TC incidence has been rising [25]. These two aspects can mainly be provoked by environmental but also genetic influences [26]. TDS means the malformation of the fetal testicles leading to cryptorchidism (non-descending of the testicles), hypospadias (malformation of the urethra), atypical spermatogenesis, and from this to TC. The potential risk that these dysplasia lead to TC were shown to be elevated by a 2.3 - 3.8-fold (cryptorchidism), 2-fold (hypospadias), and 1.6-fold (atypical spermatogenesis), respectively [26–29]. But studies have already shown that surgical reconstruction, named orchiopexy, can reduce the risk of TC. Hereby, the earlier the repositioning is conducted, the lower the risk [30].

Furthermore, environmental influences causing TDS, and consequently TC, can occur prenatal via the placenta, later in the childhood, or adult life [31]. These influences are distinguished in rather obvious reasons like mechanical (e.g., trauma), physical (e.g., heat) and microbiological (e.g., infection) incidents, and relatively multifaceted reasons like maternal estrogen levels during pregnancy or chemical exposures (e.g., pesticides) [31–37]. Especially the exposure to chemicals is an obscured issue since the contact can go unnoticed on a daily basis as these chemicals can be part of air pollution, hygienic and daily care products, packaging and can also be bioaccumulated along the food chain [38,39]. These compounds include plasticizer (e.g., phthalates), persistent organic pollutants (e.g., polychlorinated biphenyls (PBC)), and pesticides (e.g., dichlorodiphenyltrichloroethane (DDT)) [40–42]. These substances can act as environmental endocrine disruptors. By this, they disturb the endogenous hormone signaling leading to an impaired prenatal development and function of the reproductive system and conclusively (reduced) infertility [26,31].

Besides testicle dysplasia, physical conditions and health-related behaviors can become risk factors for TC. There has been a link between alcohol drinking, inactivity, high plasma lipid

levels, overweight or obesity, and the incidence of TC [5,43–46]. Some data showed that cannabis consumption correlates positively with incidence rates and at least cannabinoids impair the testicular physiology by disrupting the endocannabinoid system of the testis *in vitro* [47,48]. Further, high alcohol intake, overweight and obesity were even associated with greater mortality rates [5].

Even though, no specific mutation as cause for TC, and therefore for GCT development, has been identified, several chromosomal abnormalities and genetic alterations could be observed in diseased patients [49]. The amplification of the (iso)chromosome 12 i(12p) is observed and commonly used to identify GCT origin, for example, if the tumor is found extragonadal [50,51]. But also, mutations in the gene *Tyrosine-Protein Kinase Kit (KIT)* and genes of the *Rat Sarcoma (RAS)* family are argued as cause [52]. It is important to note that the ongoing search for GCT risk factors has led to the identification of more and more potential genetic variants. By now, a total of 78 susceptibility gene loci have been classified by genome wide association studies (GWAS) and their joint existence is associated with a 6.8-fold increased risk to develop a GCT [53].

Another risk factor for TC has been put down to the family history. Generally, when a relative under the age of 40 years was diagnosed with any type of cancer, the probability of TC in the descendent is increased [54]. Moreover, the likelihood for a diagnosis elevated when a brother (6-fold), a father or son (4-fold) or maternal or paternal uncle (2-fold) were previously diagnosed with TC [55]. Contrariwise, a study of four brothers, all diagnosed with TC, showed no family predisposition and no genetic abnormalities supporting the influence of environmental factors [56]. After the initial diagnosis, the risk to form a contralateral tumor was at 5 %, but stratified for the subtypes, the risk was 8 % for primary NS and 4 % for primary SE [57]. Altogether, the risk factors for TC are multifaceted and need further exploration in the upcoming years.

1.1.3 Histological classification of TC

The previously introduced subtypes of GCT, SE and NS, are the two most prominent subtypes. Nevertheless, GCTs are not limited to the testes, and it is important to mention that GCT also occur in the ovaries [18]. But, for the sake of this study, only testicular GCTs will be presented. As a consequence of the long history of reclassification, complexity and contextual reasons, this chapter will give a comprehensive picture of all TC types.

The most recent update from the *World Health Organization (WHO)* in 2022 organized TC into 7 classes [58]. Two subdivisions can be made based on the association to a precursor lesion, consensual termed the *germ cell neoplasia in situ* (GCNIS) (formerly also named ‘carcinoma *in situ*’ (CIS), ‘testicular intraepithelial neoplasia’ (TIN), and ‘intratubular germ cell

neoplasia unspecified' (IGCNU)) [59]. Hence, TC is categorized into '**GCTs derived from GCNIS**' (non-invasive germ cell neoplasia, the germinoma family of tumors, non-seminomatous GCTs, mixed GCT, and GCT of unknown type) (focus of this work) or 'GCTs-unrelated to GCNIS' (prepubertal GCTs: teratoma (TE), yolk-sac tumors (YST), testicular neuroendocrine tumor, mixed TE / YST, and post-pubertal spermatocytic tumor). Further categories have been based on the stromal cell origins like Leydig and Sertoli cell tumor ('sex cord stromal tumors of the testis') and the tumor's location in the testis appendages like the testis rete or epididymis ('ovarian type tumors of the collecting ducts and rete testis', 'tumors of the collecting duct and rete testis', 'paratesticular mesothelial tumors', and 'tumors of the epididymis') (**Figure 2a**) [58,60,61].

Looienga et al.'s refined classification system focusing particularly on the tumor cell origin and potency, divided GCTs into seven types: type 0 (fetale inclusion), pädriatic type I (TE, YSTs), type II (SE, NS), type III (spermatocytic tumors), type IV (dermoid cycst or matured TE), type V (hydatidiform mole) and type VI (somatic-derived) [18].

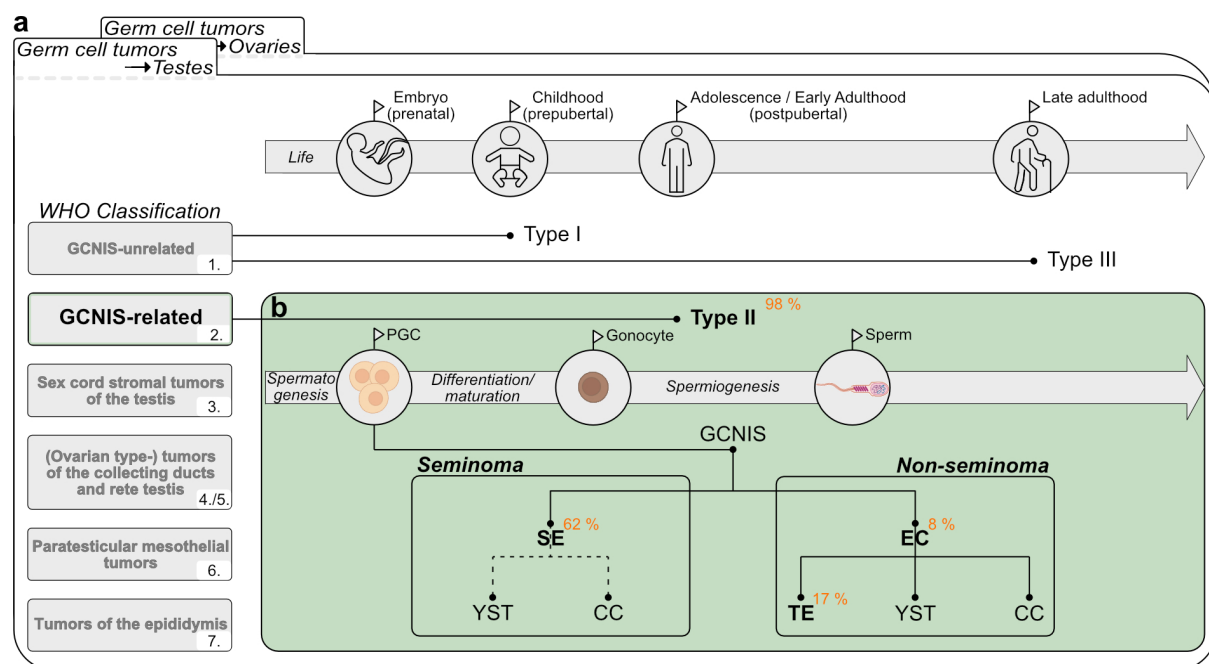


Figure 2: TC classification and development.

(a) WHO classification of TC (WHO 1. - 7.) and life course, and (b) special focus on the most common GCNIS related (WHO 2.) type II in green with the course of spermatogenesis. This type mostly occurs during adolescence and early adulthood in contrast to the GCNIS unrelated type I (childhood) and type II (late adulthood). In green: the genealogy of the subtypes SE and NS deriving from an aberrant developing PGC prepubertal, which gives rise to the GCNIS from where SE and EC, the stem cell population of NS, emerge. Dashed lines illustrate newly postulated lineages. Upper arrow indicates the different life stages and lower arrow illustrates the spermatogenesis in a time-dependent manner. In bold: the subtypes focused on in this work (SE, NS: EC and TE). In orange: the distribution of diagnosis with 98 % of all TC cases being type II from which 62 % are SE, 8 % EC and 17 % TE. Partially created with BioRender.com by Alexa Stephan. Illustration based on [7,58,60] CC: choriocarcinoma; EC: embryonal carcinoma; GCNIS: germ cell neoplasia *in situ*; NS: non-seminoma, PGC: primordial germ cell; SE: seminoma; TE: teratoma; YST: yolk-sac tumor.

Both, GCNIS-related and -unrelated GCTs, originating from a germ cell, are further subclassified into type I (pre-pubertal non-GCNIS TE and YSTs), **type II (post-pubertal GCNIS associated SE and NS: embryonal carcinoma (EC), TE, YST, and choriocarcinoma (CC))** (focus of this work), and type III (spermatocytic tumors in older men) (**Figure 2b**) [58]. As stated previously, type II GCT account for over 98 % of all TC diagnosis [8]. Hereby, the detailed distribution for the subtypes of type II were in 2015 / 2016 as following: SE (62 %), NS (EC 8 %, malignant TE (17 %), CC (2 %) YSTs (1 %), and others / unspecified (10 %) [7]. That is why this study specifically concentrated on type II GCT, mainly SE, and EC and TE (NS).

1.1.4 Tumor staging and prognosis

Mostly, TC is noticed by the patients themselves because of observable stiffness or expansion of the testes. But for the decision on the tumor treatment option, the exact tumor degree is important. Therefore, based on the clinical visual assessment and palpation, imaging procedures, primary and secondary diagnostic, the status of the cancer disease is evaluated [62].

Firstly, the anatomical severity is assessed by the clinical TNM classification ('Primary Tumor', 'Lymph Nodes', 'Metastasis') defined by the *Union for International Cancer Control* (UICC) and the *American Joint Committee on Cancer* (AJCC) [63]. Therefore, the size and infiltrations rate of the primary tumor (T category), the infestation of the lymph nodes (N category), and the metastasis status (M category) is determined. Regarding the further detailed pathological TNM classification, also serum markers are included in the assessment. In routine diagnostic the most common markers are *α -Fetoprotein* (AFP), *Human Chorionic Gonadotropin* (β -hCG), and *Lactate Dehydrogenase* (LDH), which can be conveniently tested in blood [60,64]. Higher clinical staging (CS) (0 - III) and increased substaging (A - C / S) represents a more severe cancer stage [63]. To determine the tumor's spread, a computer tomography (CT) occasionally combined with contrast agent-based positron emission tomography (PET-CT) is commonly performed [65].






Secondly, in 1997, a global consortium of the top clinics for TC treatment developed a staging system based on prognostic factors by analyzing data of approximately 5900 chemotherapy-treated patients with metastatic SE and NS [66]. The *International Germ Cell Cancer Collaborative Group* (IGCCCG) therefore defined three major groups: 'Good Prognosis', 'Intermediate Prognosis', and 'Poor Prognosis' (**Table 1**) [66]. These groups are based on marker levels of AFP, β -hCG, and LDH, the occurrence of metastases and can be used for OS and distribution estimations [66]. Hereby, the determination of the serum markers is time

critical and, in 2021, some minor changes were applied, which improved the estimated OS for patients with NS [67,68].

In the age range of 30 - 50 years around 95 %, 86 %, and 71 % of patients with SE survived for 3, 5, and 10 years, respectively [69]. Even relapsed patients faced an exceptional high 5-year OS when they were initially staged in CS I [70]. Fortunately, nowadays the survival rates for initial metastatic or relapsed cSI SE and cSI NS patients showed no significant or neglectable differences (93.1 vs. 96.1 %; 93.3 vs. 88.7 %) [71]. But, as depicted in **Table 1**, the general estimated 5-year OS for NS falls from 96 % to only 67 % for poor prognosed patients. And further, with standard treatment the OS rates for patients with EC are at 90 % ('Good Prognosis') and at 75 % ('Intermediate Prognosis'), but only at 45 % ('Poor

Table 1: IGCCCG classification for GCTs.

Prognosis-based staging system of GCTs divided into 'Good', 'Intermediate', and 'Poor Prognosis' with the patient distribution (%), 5-year OS (%), site of tumor, and tumor marker concentration measured right before therapy start. NPVM: non-pulmonary visceral metastases. Overview designed by Alexa Stephan according to the guidelines [62], updates from 2021 are included [68]. GCT: germ cell tumor; NS: Non-seminoma; OS: overall survival; SE: seminoma.

Prognosis	Factors	GCT subtype	
		SE	NS
Good	Proportion	90 % 	56 % 
	5-year OS	86 %	96 %
	Site	Any primary site <u>AND</u> No NPVM <u>AND</u>	Testis / retroperitoneal primary <u>AND</u> No NPVM <u>AND</u>
	Marker	Normal markers normal AFP, any β -hCG, any LDH	Good markers, all of: AFP < 1000 ng / mL, β -hCG < 5000 iu / L (1000 ng / mL), LDH < 1.5x upper limit of normal
Intermediate	Proportion	10 % 	28 % 
	5-year OS	72 %	89 %
	Site	Any primary site <u>AND</u> NPVM <u>AND</u>	Testis / retroperitoneal primary <u>AND</u> No NPVM <u>AND</u>
	Marker	Normal markers normal AFP, any β -hCG, any LDH	Intermediate markers, any of: AFP \geq 1000 - 10000 ng / mL or β -hCG \geq 5000 - 50000 iu / L LDH \geq 1.5x - 10 N
Poor	Proportion	No poor prognosed patients	16 % 
	5-year OS		67 %
	Site		Mediastinal primary <u>OR</u> NPVM <u>OR</u>
	Marker		Poor Markers, any of: AFP > 10000 ng / mL or β -hCG > 50000 iu / L (10000 ng / mL) LDH > 10x upper limit of normal

Prognosis') [72]. Altogether this underlines the importance of precise staging and tailored treatment.

Finally, based on the histological classification (**chapter 1.1.3**), disease stage (TNM and IGCCCG classification) (this **chapter 1.1.4**) a suitable treatment option will be chosen. The treatment options for TC will be described in the next chapter.

1.1.5 Guidelines for GCT treatment

Since 2008, the *Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften e.V.* (AWMF), the *Deutsche Krebsgesellschaft e.V.* (DKG) and the *Deutsche Krebshilfe* have worked together to establish consensus- and evidence-based medical guidelines [62]. In Germany, the highest quality guidelines are S3-guidelines, which are well established in the treatment of TC [62]. For this reason, the main therapy strategies for TC with the focus on SE and NS will be presented in the following sections.

Obviously, the chosen therapy option is adjusted to the initial diagnosis / stage and can either intend for surveillance, (neo-)adjuvant chemo- / radiotherapy, and surgical removal or a combination of these options. In the vast majority (99 %) of TC diagnosis, surgery is conducted as first line therapy [73]. This can either lead to partial resection or complete removal of one or both testicles known as orchiectomy or ablatio testis [74].

One fundamental part of curative TC treatment is the application of chemotherapeutics. Therefore, it is righteous to briefly touch on the revolutionizing discovery of chemotherapeutics (vinblastine, bleomycin, cisplatin, etoposide, ifosfamide) for cancer treatment, especially TC, in the last century. Back in the early 1900's, the cure rates for SE had already been at 94 % with orchiectomy and radiation therapy [75,76]. However, metastatic NS (EC or TE) treated with radiation had left no survivors after 5-years. Even for patients with non-metastatic NS the survival rates had been at only 50 % when orchiectomy and retroperitoneal lymph node dissection (RPLND), a technique for removing local lymph nodes in the abdominal cavity, were conducted [75,76]. Then, in 1965, the discovery of the cell division inhibitory capacity of *cis*-diamminedichloroplatinum(II) (cisplatin) had ushered a new era for the field of oncology [77]. Remarkably, the application of cisplatin had led to the complete remission in 81 % of refractory TC patients showing the outstandingly high chemosensitivity of TC [76,78]. Thereafter, this had entailed the further favorable findings of the cytostatic agents vinblastine, bleomycin, etoposide and ifosfamide, which had then been used in combination treatments (cisplatin + vinblastine + bleomycin (PVB), and etoposide + cisplatin (EP)). Ultimately, this has laid the foundation for today's conventional treatment – the superior combination of bleomycin, etoposide, and cisplatin (BEP) in the late 1900's and early 2000's [76,79,80]. Nevertheless, if intolerance towards bleomycin or a lung disease

exists, the EP treatment is still the preferred option of choice and usually involves one additional cycle than the standard treatment [62].

Beginning with the lowest stage cS0, meaning a GCNIS, the progenitor cell of SE and NS. The study of Brabrand et al. showed particularly that the probability to develop a GCT without any treatment amounted to 61 % 7.5 years after the initial diagnosis [81,82]. This risk can be reduced when treated with chemotherapy, whereas low doses showed similar effects (58 %) and higher doses had superior effects (22 %) [62,81]. However, the greatest results were exceeded with the rather radical options like ablatio testis or radiation therapy with very low probability with a relapse in the follow-up controls [62,83].

For non-metastatic SE cSI excellent OS are achieved regardless of the treatment option (surveillance, radio- / chemotherapy). As a result of the extremely high curability of low staged GCTs, the prevalent goal is to also minimize the overall toxicity for patients. Thus, for non-metastatic SE cSI (and cS0), when chemotherapy is necessary, it is treated with the less toxic cisplatin analogue carboplatin. In contrast, for the less favorable non-metastatic NS cSI with low-risk surveillance is recommended, and but with high risk one or two cycles of BEP are suggested [62].

In case of an advanced disease, the standard procedures for metastatic SE are radiation (cSIIA) and chemotherapy (cSIIB) with 30 Gray (Gy) / 36 Gy overall dose and 3 x BEP or 4 x EP [84]. The recurrence free survival rate for radiated cSIIA patients was at 100 % (after approximately 3 years), but lower for cSIIB patients (87.4 % after 2 years) [85]. Associated therewith, Giannatempo et al. showed a reduced relapse rate and lower side effect rates in chemo-treated cSIIB patients compared to patients with radiotherapy [86]. Therefore, some international consortiums, like the *European Association of Urology* (EAU), have already recommended chemotherapy as preferred option for both stages [87]. However, this modification has not been conclusively suggested in the S3-guidelines [62,86]. Therefore, the risk-benefit ratio must be discussed with the patient.

For metastatic NS cSIIA / B, the decision for a suitable treatment option is based on the presence of elevated marker levels. Patients evaluated with 'Good Prognosis' according to IGCCCG (**Table 1**) along with positive markers receive chemotherapy (3 x BEP). Further progressed NS cSIIA / B patients with an 'Intermediate Prognosis' grouping are treated with 4 cycles of BEP. Potential residual tumors are removed by surgery (residual tumor resection (RTR)). In case of negative markers, active surveillance or RPLND is recommended (as former surgery and consequential imaging techniques can lead to false-positive results). Dependent on the individual's further course of disease the staging is reassessed, and for potential relapses different options are proposed: close monitoring, treatment with BEP,

surgical removal (RTR) or RPLND. When the primary tumor was classified as pure TE without markers elevation a RPLND is recommended [62].

When patients are diagnosed with the least favorable tumor stage, cSIIC and cSIII, and the disease being in a life-threatening state, chemotherapy is given priority to ablatio testis. Nonetheless, even after systemic treatment vital tumor residuals are found in the testis of NS patients, but not SE patients. Therefore, surgery should be mandatory as secondary step [88]. For SE and NS, 3 x (both with 'Good Prognosis') or 4 x (both with 'Intermediate Prognosis', and NS with 'Poor Prognosis') BEP is recommended. Again, if there is a contraindication to bleomycin, patients may receive 4 cycles of EP, but with that, mortality is increased [89]. In that case, a suggested alternative for BEP is PEI, also called VIP (cisplatin + etoposide / **Ve**Pesid + ifosfamid) with similar OS, but higher hematotoxicity. If the tumor markers are not decreasing after primary standard chemotherapy, a high dose PEI and autologous stem cell transplantation is attempted [62].

As aforementioned, under the circumstance of a relapse, the disease with initially lower staging is restaged and accordingly treated. In the case of late relapses, therapy of refractory tumors or metastasis with conventional dose chemotherapy can be unsatisfactory. Then, the cancer is managed with salvage therapy attempts, which includes further RTR, chemotherapy dose intensification (high dose cisplatin) or other chemotherapy strategies like TIP application (paclitaxel, ifosfamide and cisplatin) [90].

Even though TC generally demonstrates high curability, the therapy regimens imply acute and long-term toxicities like infertility, hypogonadismus (reduced testosterone production because of Leydig cell depletion), secondary malignancies, leukemia, cardiovascular toxicity, infections, pulmonary complications, fatigue, neuro- and ototoxicities [91]. Generally, for the success of therapy, precise dosing and timing is always essential as the dose intensity positively correlated with therapy outcome [92]. In any case, the risk-benefit ratio of the therapy options should be discussed with the patient since life changing side effects, like sterility, can occur. Hence, if surveillance is feasible, this option should be preferred to preserve gonadal function [62]. Lastly, besides quality of life, refractory therapy resistant tumors remain an issue leaving young patients with little prospect towards the future [92,93].

1.1.6 Physiological testis development and spermatogenesis

To fully understand the development of GCTs, it is fundamental to have an insight into the physiological human development with differentiation and maturation of the male gonads and gametes, the germ cells. The gametes, emerge inherently from the primordial germ cells (PGC) and today's level of knowledge suggests that GCT cells (type II)

particularly derive from a precursor lesion, the GCNIS, which priorly stems from a deviated PGC. Therefore, GCT cells already arise during the embryogenesis.

The embryogenesis covers the extensive human development from an one-cell-state to a full functional fetus until the child's birth (germinal stage, embryonic stage, specification).

This route begins with the germinal stage meaning the formation of a zygote by merging a sperm and an egg cell (fertilization) continued by the cell division of the one-cell-state to a ball of cells – from the blastomere (< 8 cells) to the morula (> 8 cells) (cleavage) [94]. Accompanying with the progress of development, the cell's potential to create all different types of cell fates changes. In the zygote, blastomere, and morula state, the cells are omnipotent as they can still differentiate into all various cells of the embryo, but also the embryo-supporting extraembryonic tissue [18,95,96]. Then, with the reorganization of the morula to a sphere of cells surrounding a fluid-filled cavity, the blastocyst emerges (blastulation). Here, the outer cell layer, the blastoderm or more specifically the trophoectoderm / trophoblast, surrounds the blastocoel, the inner compartment, including the differentiated inner cell mass, also known as embryoblast as this gives rise to the embryo [94]. Now, the inner cell mass is defined as totipotent (naïve embryonal stem cells) and is characterized by a defined gene signature, substantially the gene expression of the *SRY-Box Transcription Factor 2* (SOX2) [18,95,96].

In the embryonic stage, after the implantation in the wall of the uterus, the inner cell mass differentiates into two cell layers, the somatic cells of the upper epiblast or primitive ectoderm and the lower hypoblast or the primitive endoderm (formation of the embryonic disc). As a result, two cavities emerge, the primitive yolk-sac and the amniotic sac. Eventually, the epiblast is the predecessor to the embryo by further differentiation (somatic cell lineages and PGCs), and the hypoblast forms the extraembryonic membranes and tissue [94]. The cells of the epiblast are now referred to as pluripotent (primed embryonal stem cells) and are expressing the pluripotency sustaining *POU Domain Class 5 Transcription Factor 1* (POU5F1) / *Octamer-Binding Transcription Factor 3 / 4* (OCT3 / 4) [18,95,96].

The formation of the embryonic disc is the transitional process to the next phase – the gastrulation. This phase commences with the formation of new structures like the primitive streak and includes the body axis and germ layers development [94,97]. Here, the germ layers are divided into ecto-, meso-, and endoderm, which give rise to either the respiratory and digestive system or heart, bones, muscle and urinary system, or skin and nervous system, respectively. The development of the embryo then continues with the neurulation and organogenesis followed by the fetal stage [94].

Explaining the process of embryogenesis is important as the PGCs can be detected as early as two weeks after fertilization originating from cells of the epiblast [97,98]. These epiblasts

undergo specification and hence avoiding the other epiblasts' somatic cell fate [98]. Further reprogramming by re-expression of pluripotency factors and epigenetic remodeling occurs during the migration of the early PGCs from the hindgut, a part of the digestive tube, along the body midline towards the genital ridge. The colonization of the late PGCs in the genital ridge, the progenitor of the sex cords, which then differentiate into the gonads (here testicles), is followed by the spermatogenesis [96].

The specification of epiblasts to early PGCs is determined by the *Bone Morphogenic Protein* (BMP) and *Wingless-Type Protein* (WNT) secreted by the surrounding extraembryonic ectoderm [18,98]. This prevents the somatic cell fate and supports PGC fate by expression of the *Transcription Factor AP-2 Gamma* (*TFAP2C*), *B Lymphocyte-Induced Maturation Protein 1* (*BLIMP1*), *POU5F1* / *OCT3 / 4*, and *SOX17*, (switch from *SOX2* to *SOX17*) [18]. The transcription factors *SOX17* and *SOX2*, partner with *OCT3 / 4* and determine either pluripotent PGC-like or embryonic stem cell-like cell fate, respectively [96]. During migration, further reprogramming of the early PGC is defined by expression of chemokine receptors (*C-X-C Motif Chemokine Receptor 4* (*CXCR4*) and *KIT*, and by epigenetic remodeling through erasure of the parental genomic DNA methylation patterns (genomic imprinting) (the general process of DNA methylation is further explained in **chapter 1.2.3**) [18,96,97]. Having surface receptors is essential for PGCs as they are heavily dependent on external signals during their course of migration, and colonization relies on the chemotactic gradient of the *C-X-C Motif Chemokine Ligand 12* (*CXCL12* / *SDF-1*), the ligand to the *CXCR4* receptor, in the gonadal niche [99]. Late PGCs, lacking genomic imprinting, arrive in the gonadal niche leading to the completion of reprogramming (DNA remethylation) [100]. Hereby, PGCs transform from latent pluripotency (migration), which means they do not have the ability to differentiate into all three germ layers unlike naïve pluripotent cells, into latent totipotency (colonization) [18,95]. After sex determination, male PGC give rise to the gonocytes [96].

The process from PGCs in the fetal stage to motile spermatozoa (sperm cells) in the adult life is called spermatogenesis. The final stage of spermatogenesis, the spermiogenesis, occurring continually in adult men, describes the maturation and differentiation of undifferentiated spermatogonia (1) to spermatocytes (2 & 3) to spermatids (4) into spermatozoa (5) (**Figure 2b** and **3**) [94]. Thereby, the cells migrate upwards along the supporting Sertoli cells into the lumen of the seminiferous tubules, and travel via the rete testis, the efferent ductus, the epididymis and then the ductus deferens to the ureter (**Figure 3a**). The Sertoli cells line the inner side of the seminiferous cords, form reciprocal connections by tight junctions to build a testis-blood barrier where the gonocytes are solely dependent on the Sertoli cells' secretion products (**Figure 3b**) [101]. This protective measure makes the testicles an immune privileged organ shielding the germ cells from toxins and pathogens [102]. The convoluted system of seminiferous system represents the functional

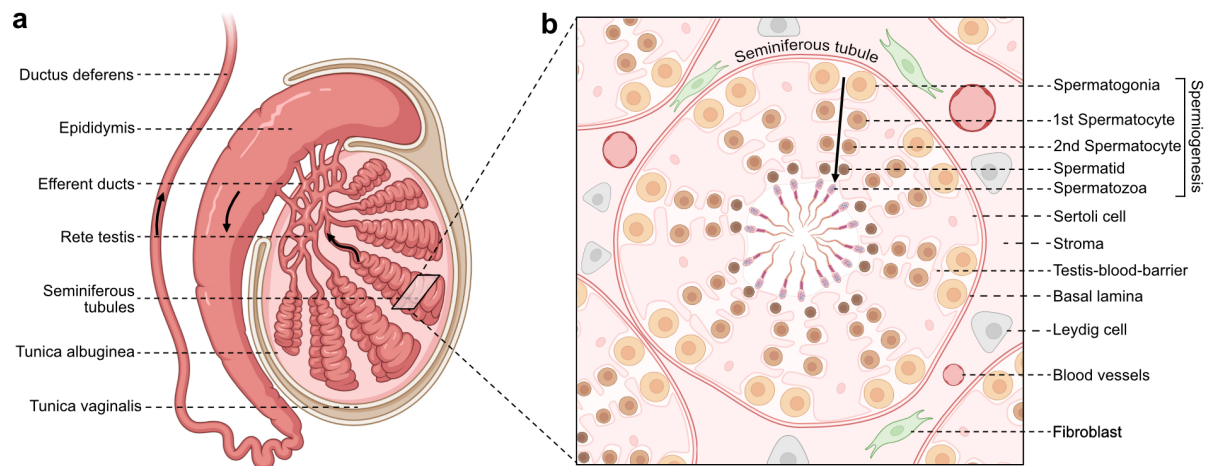


Figure 3: Anatomy of the testicle.

(a) Vertical section of the testicle. (b) Transverse section of a seminiferous tubule as magnified view to show location of spermiogenesis (spermatogonia to spermatozoa), and the surrounding microenvironment meaning Leydig cells, FBs, and blood supply. Arrows indicate route of sperm secretion. Partially created with BioRender.com by Alexa Stephan. Based on [101].

testicular parenchyma. The parenchyma is enveloped by the stromal tunica albuginea containing blood vessels, muscles cells, Leydig cells and FBs (**Figure 3b**) [103]. Hereby, the Leydig cells are responsible for the testosterone production, which in hand influences the gonadal development and function [104]. And lastly, the poorly described testicular (myo)FBs, earlier called compartmentalizing (co-) cells, are randomly distributed within the testicular stroma [105]. Unfortunately, testicular FBs or stromal cells are frequently only mentioned peripherally in single cell (sc) analysis [106,107]. But, the secretion of CXCL12 for the perinatal establishment of the gonadal niche might be traced back to these stromal cells [108,109].

1.1.7 Pathological testis development: the tumorigenesis of GCTs

So far, it is postulated that the GCT type II originates from an abnormal developed PGC, which gives rise to a GCNIS (**Figure 2**). As mentioned before, the normal development of the PGCs is dependent on the surrounding microenvironment. Hence, it is not surprising that the microenvironment also plays a critical role in the development of GCTs.

Generally, the development of the precursor lesion, the GCNIS, can be explained by the external risk factors as mentioned in **chapter 1.1.2**. The rise of SE is postulated as the default route of the GCNIS [110]. SE resemble histologically, epigenetically and based on the expression of the *Homeobox Transcription Factor Nanog* (NANOG), *Preferentially Expressed Antigen In Melanoma* (PRAME), *POU5F1 / OCT3 / 4*, and *SOX17* the PGC or GCNIS, respectively. In contrast, EC represent the stem cell population of the NS by expressing the transcription factor *SOX2*, not *SOX17*, and being able to differentiate into all three germ layers and extraembryonic tissue. Therefore, EC can give rise to TE, YST, and CC [60,96].

The dependency of SE on *SOX17* expression was demonstrated by the knockdown of *SOX17* in the only existing SE cell line, TCam-2. This resulted in the loss of SE phenotype by downregulation of pluripotency factors [111].

When reviewing the previous chapters, there is a noticeable involvement of the environment. Diverse external risk factors greatly influence the development of GCTs. Understandably, that the environment on a smaller, cellular scale also influences the development of the different types of GCT type II. Here, we get to the local environment – the (tumor) microenvironment (TME). *In vitro* and *in vivo* experiments showed the plasticity of GCTs explaining the GCT variety and occurrence of mixed GCTs, but also explaining the difference in GCT subtyping in the initial diagnoses and followed relapses. The *in vitro* treatment of TCam-2 with FB conditioned medium (CM) (+ *Fibroblast Growth Factor 4* (FGF4)) showed the potential of SE to differentiate into CC and YSTs omitting an intermediate step with EC proportions. Therefore, EC may not be the only cell type with the capacity to differentiate into extraembryonic tissue [112]. Further *in vivo* analyses showed that the murine TME of the flank even reprogrammed the SE cell line into an EC-like cell fate by inhibition of the BMP signaling pathway and re-expression of *SOX2* [113]. Essentially for this reprogramming was *SOX2* [114]. When xenotransplanted *SOX2*-deficient TCam-2 cells faced the murine somatic TME, no EC-like cell fate was observed but YST-like populations positive for AFP and *Forkhead Box A2* (*FOXA2*) developed [114]. The only way to maintain the SE phenotype was by a dual knockdown of *SOX2* and *FOXA2* even after confrontation with the TME [115].

In the vicinity of the tumor, the surrounding area is called the TME. Regarding the TME in GCT, the study of Skowron et al. investigated the reciprocal influence of TME cell lines (endothelial cells, macrophages, normal FB (nFB), and T lymphocytes) and tumor cell lines (SE, EC, CC, and YST) *in vitro*. Firstly, the secretome of GCT and TME cell types were analyzed independently, and, secondly, the altered gene expression patterns after 3D co-culture were evaluated individually in the distinct cell populations. According to the *GeneOntology* (GO-) analysis and *Search tool for the retrieval of interacting genes / proteins analysis* (STRING) algorithm, the factors identified by mass spectrometry (MS), commonly secreted by all TME cells, were mainly associated with biological processes such as ‘T cell activation’, ‘IGF receptor signaling pathway’ and ‘immune response’. After the direct cell-cell contact of TME and GCT cells by 3D co-culture, the TME cells showed elevated expression levels of genes associated with extracellular matrix (ECM) modulation and processes such as cell adhesion, cell-cell communication, immune response, inflammation, and morphogenesis. Based on these altered cellular processes an activation of stromal cells into a pro-inflammatory and pro-tumoral state through direct interaction with GCT was suggested. Conversely in GCT cells, the 3D co-culture led to the upregulation of genes involved in the organization of ECM and the integrin signaling pathway [116]. In addition, the treatment of

GCT cell lines with FB CM led to reduced cisplatin sensitivity, which was accompanied by altered gene expression of known therapy resistance factors [116,117]. These factors were classified by Galluzzi et al. into pre-, on-, post-, and off-targets. Hereby, pre-targets are referring to mechanisms hindering cisplatin binding to the DNA, either through enhanced export out of the cell, diminished import into the cell, or even detoxifying / metabolizing mechanisms. On-target resistance mechanisms refer to putatively enhanced DNA repair mechanisms upon formation of DNA-cisplatin-adducts. Post-target resistance mechanisms are referring to reduced apoptosis-induction upon cisplatin treatment. Other non-relating mechanisms reducing the cisplatin efficacy are categorized as so called off-target resistance mechanisms [117]. For instance, there was an increased expression of factors involved in DNA repair and the efflux of cisplatin as well as decreased expression of apoptosis inducers (*MRP2*; *ERCC2*; *BCL2*, *BCLXL*, *TP53*; and *ERBB2*). Summarizing, the reciprocal signaling cascades between GCT and TME cells led to the activating effect of TME cells, notably FBs, and the supporting effect in cisplatin resistance in GCT cells [116]. As these discoveries underline the importance of the TME, this will be further explained in the next chapter.

1.2 The tumor microenvironment

The TME is comprised of the cellular and non-cellular compartments. Besides the tumor cells, various cell types are found in the TME, like infiltrating immune cells (B-, dendritic, natural killer, and T-cells, and macrophages), endothelial cells of the vascular system, tissue-specific cells like Sertoli and Leydig cells in the testis, and FBs. Within tumors and due to their peculiar characteristics, FBs are referred to as CAFs [118]. The non-cellular part of the tumor describes the ECM consisting of glycoproteins (collagens, elastin, fibronectin, and laminin) and the subgroup of glycosaminoglycans (chondroitin-, heparan- and keratan sulfate, and hyaluronic acid) [119]. These proteins are recognized and bound by CD44, discoidin domain receptors (DDR), integrins and receptors for hyaluronan mediated motility (RHAMM) on the tumor cells [119]. The following chapters provide an insight into the current understanding of origin, development, and classification of CAFs, their role in therapy resistance and their potential as novel theranostic targets in cancer research.

1.2.1 From FB to CAF: cell origin and development

FBs, as a part of the stroma, were firstly described by Virchow in 1858 [120]. Later, Tytler described their incidence in a tumoral context as he identified FBs in the TME of osteochondrosarcoma [121]. Today, it is known that FBs exist in various tissues of the body presenting intra- and inter-organic differences and playing a crucial role in tumors as CAFs [122].

The suffix *-blast* (ancient greek for 'blastos', 'sprout', 'shoot') normally indicates a partially (un-) differentiated cell state and the involvement in the embryonic development whereas for *fibro-blasts*, it refers to their metabolic activity as they are non-terminally differentiated cells [122]. In literature, different expressions are used for FBs like fibrotic tissue, fibrogenic or mesenchymal (stromal) cells, myofibroblast and more, dependent on the timeline, cell origin and activation state. Fundamentally, the FB lineages has been traced back to the mesoderm, but also the ectoderm and many diverse progenitor cells are known [122]. FBs are known for their resilience as they can be easily cultivated and isolated, even post-mortem [123]. They are known to sustain tissue homeostasis, to support developmental and wound healing processes, and to interfere with the tumor growth [122]. Further, FBs can be reprogrammed to induced pluripotent stem cells and serve as feeder layer in the cell culture [124,125].

Generally, FBs are defined by morphology (long, spindle-like) and by positivity / negativity for molecular markers with *Fibroblast Activation Protein Alpha* (FAP / *FAP*), *Fibroblast-Specific Protein-1* or *S100 Calcium Binding Protein A4* (FSP1 / *S100A4*), *Actin Alpha 2 Smooth Muscle* (α SMA / *ACTA2*), and *Vimentin* (VIM / *VIM*) being the most common ones. However, these factors are not exclusively expressed in FBs suggesting a combination for

identification. Moreover, the era of single cell RNA sequencing (RNAseq) analyses showed the substantial intra- and inter-organ heterogeneity of FBs and associated molecular markers [122]. FBs are the main source of the structural macromolecules as they are producing glycoproteins (collagens, elastin, fibronectin, hyaluronic acid, laminin, chondroitin-, heparan- and keratan sulfate), and secreting their enzymatic counterparts for degradation (metalloproteinases (MMP) 1 - 28, and lysyl hydroxylases (PLOD1 - 3)) [119]. In the human body, the organs differ in tissue stiffness and elasticity due to the diversity in function, therefore organ-specific structural organization controlled by FBs is required [126].

Under physiological conditions, quiescent FBs are equally and reversibly activated and deactivated to maintain the structure and elasticity of distinct organs (e.g., skin, heart, lung, liver) by sustaining an equilibrium between construction and deconstruction [126].

Under patho-physiological conditions, like tissue damage, it has been shown that wound healing is a very well-orchestrated process in which FBs play a crucial role. Resident FBs proliferate, migrate, and eventually differentiate into myofibroblasts to establish a provisional matrix through ECM secretion facilitating wound closure. This matrix is temporary and undergoes remodeling to aid wound resolution. Under some circumstances, like recurrent tissue damage or chronic inflammation, excessive ECM deposition can lead to fibrosis. In this case the stroma has stiffened, which can negatively affect organ function and, over the long term, support tumor formation [127].

In the tumor context, FBs are permanently activated and referred to as CAFs. It has been shown that CAFs are one of the most abundant and most prevalent cell type in the tumor cell-cell communication [128]. Activation can be initiated by different stimuli like mechanical stress, hypoxia, reactive oxygen species, and signaling proteins like growth factors, chemokines, and cytokines [129]. But CAF activation can be also induced by anti-angiogenic or chemotherapeutic treatment [130–132].

In 1986, the pathologist Dvorak published the well-known statement ‘Tumors: wounds that do not heal’ because of the similarities between the wound healing process and the tumor stroma creation [133,134]. Hence, it is more appropriate to refer to CAFs as an atypical activation state of FBs rather than a unique cell type. In particular, the pathological state of CAFs has been shown to be reversible. Kim et al. reported the reversion of CAF differentiation by application of the small molecule Scriptaid, which inhibits epigenetic regulators. This led to lower α SMA amounts in CAFs suggesting the reversion. In addition, in a 3D co-culture model of CAF and tumor cells, the inhibition resulted in a diminished ECM secretion, cell contraction, stiffness, and cell invasion, and delayed tumor growth *in vivo* [135]. Furthermore, with the mitochondrial inhibitor, dihydrorotenone, CAFs could be deactivated and lost their tumor supporting function in stomach cancer *in vitro* and *in vivo* [136].

1.2.2 Intra- and inter-tumoral heterogeneity leading to numerous CAF subtypes

The absence of a defined FB nomenclature because of their molecular diversity is reflected in the classification of CAFs. CAFs are a phenotypically dynamic cell type leading to numerous intra- and inter-tumoral subtypes. Despite the general tumor-promoting association of CAFs, there are different subtypes based on expression patterns in combination with the resulting functionality. Mainly, the following subtypes are described: myofibroblast CAFs (myCAF), inflammatory CAFs (iCAF), and antigen presenting CAFs (apCAF). But these classifications can be further extended to vascular CAFs (vCAF), cycling CAFs (cCAF), progenitor CAFs (proCAF), matrix producing CAFs (matCAF), and developmental CAFs (dCAF) [137,138].

MyCAs and iCAs can be found in many solid tumors such as in breast, cervical, colorectal, gastric, liver, lung, pancreatic, and prostate cancer [135–145]. MyCAs (high α SMA, low IL6) had simultaneously tumor restraining or supporting functions whereas iCAF (low α SMA, high IL6) have tumor promoting properties by secreting inflammatory proteins [137].

But depending on the tumor, other marker specific CAF subtypes have been described diversifying the CAF field. When looking closer only into as inflammatory described CAFs, the subtyping gets rather complex. Chen et al. defined a more specific inflammatory $CXCL1/2/12/14^+$, $IL6^+$ subtype in bladder cancer, which promoted tumor proliferation when co-cultured with bladder cancer cells *in vitro* [146]. The immunosuppressive FAP^+ , $CD29^+$, α SMA $^+$ subtype described in breast cancer could be further divided into subgroups; proinflammatory CAF ($CXCL12^+$ / $SOD2^+$), predominant in patients with more aggressive triple-negative breast cancer, and myCAF-like CAFs ($COL1A2^+$ / $TAGLN^+$), associated with luminal A-type tumors [147]. In single cell RNAseq analyses in head and neck, and lung carcinomas the same immunosuppressive FAP^+ / $CD29^+$ / α SMA $^+$ subtype appeared. In lung cancer, the detection of this CAF population was significantly increased in patients who did not respond to immunotherapy [147]. The most prominent inflammatory $CD146^+$ / $IL6^+$ subtype in intrahepatocellular cholangiocarcinoma promoted the tumor cell growth *in vivo* when co-injected, which could be inhibited by IL6 antibodies and inhibitors of the IL6 pathway [148].

1.2.3 CAFs and stromal cells as diagnostic, predictive, and prognostic tool

Molecular diagnostic, predictive, or prognostic biomarkers are of interest for the patient's clinical course meaning disease occurrence and progression. Several studies verified that the pure CAF proportion itself, the occurrence of a single or several CAF subset specific markers can be used in various tumor entities as reliable diagnostic and prognostic marker for tumor grading, survival, and potential metastasis.

One common **diagnostic** tool for cancer imaging is a PET-CT scan. CAF's rise in cancer research and its positivity for FAP led to the development of PET-tracers like ^{68}Ga -FAPi applicable in many cancers [149]. This new development bears the opportunity for theranostic approaches, combining the fields of therapy and diagnostic, as FAP targeting tracers comprising FAP inhibition ability [150]. CAFs as therapeutical target are greatly elucidated in the **chapter 1.2.5** provided below.

Besides imaging approaches, CAFs can be used for survival **predictions** and tumor progression. As in lung adenocarcinoma, the classification of tumor patients solely on a high CAF appearance correlated with poor OS and poor disease-free survival. Further, the correlation of a CAF specific set of 11 genes to pathological clinical features by analyzing several patient cohorts from *The Cancer Genome Atlas* (TCGA), proposed this distinct gene set as prognostic tool [151]. Accordingly, analysis of the TCGA breast cancer cohorts led to the identification of a CAF-related set of nine genes that reliably discriminated between low- and high-risk patient groups based on differences in OS [152].

In addition, CAF specific markers showed the potential value for tumor metastasis prediction and **prognosis**. Positive staining of CD105, a marker for breast cancer-derived CAFs and bone marrow-derived mesenchymal stem cells, could not only be positively correlated with breast cancer patient characteristics like age, and tumor size and negatively correlated with OS, but high expression of CD105 in CAF was also associated with bone metastasis events. These findings suggested CAF's CD105 positivity as potential prognostic indicator for breast cancer [153]. Immunohistochemistry stainings of the autophosphorylation level at tyrosine 397 (pY397) of FAK in human pancreatic adenocarcinoma-related CAFs showed low levels in nFBs and high levels of FBs of tumor tissue. Correlation with the grade status confirmed pY397 FAK as a valuable prognostic marker for disease-free and OS in low and moderate grade tumors [154].

Besides common tumor markers, as discussed above, another approach uses the DNA methylation pattern as prediction tool. As short introduction into DNA methylation, here, the loss of methylation (hypomethylation) and the gain of a methyl group to the nucleobase (hypermethylation) are controlled by TET1 / 2 / 3 and DNMT3A / B (*de novo*) or DNMT1 (maintenance). In the genome, high methylated regions are commonly found in CpG-dinucleotide rich sequences meaning cytosines followed by guanines on the same DNA strand (5'-3'-direction). Regions with a high frequency of CpGs are called CpG islands, which are most regularly located in gene promoters. These DNA modifications play a crucial role in embryogenesis, development, genetic imprinting (as mentioned in **chapter 1.1.6**) and, since their promoter association, in gene transcription. It is believed that hypomethylated DNA favors gene expression and hypermethylation represses gene transcription, because of their

(in)accessibility for transcription factors. An altered DNA methylation landscape is associated with tumor progression generally [155].

The examination of the DNA methylation status in liquid biopsies showed already promising results for the patient's prognosis [156]. There have also been some interesting approaches looking at the specific DNA methylation status of CAF as a prognostic marker. For instance, Ma et al. confirmed the common CAF marker FAP as reliable independent prognostic marker in various tumors. As they analyzed the TCGA cohorts, GCTs were ranking under the top ten tumor types where high FAP expression correlated with positive stromal scores suggesting high abundance of stromal cells in testicular GCTs. Conversely, high DNA methylation levels of FAP correlated with a poor overall and disease-specific survival [157]. Further, tumor subtype specific indicators were identified like in prostate isolated CAFs, *EDARADD* hypomethylation correlated with high grade tumor staging and positive affection of lymph nodes. Moreover, this low DNA methylation status of *EDARADD* correlated positively with the relapse-free survival TCGA prostate cancer cohort [158]. Whereas hypermethylation of the differentially methylated region in *CCDC68* were associated with reduced relapse-free survival compared to hypomethylation [159].

1.2.4 The development of therapy resistance due to CAFs

Several studies have shown the importance of the cell composition in solid tumors for the clinical course of cancer patients [160]. Two aspects are crucial for the success of cancer treatment: firstly, the physical accessibility of the tumor for drug delivery and penetration, which depends on fluid pressure, solid stress, and consequently tumor stiffness [126,161]. Secondly, the cell-cell interactions play a fundamental role in the drug response [160]. If the TME does not initially support the drug resistance, the drug application may eventually alter the tumor composition and cell-cell communication supporting the acquirement of drug resistance [131].

As mentioned in **chapter 1.1.5**, dependent on stage and subtype, various therapy options are available for the treatment of TC. Due to the diversity of treatment options for cancer in general, this section will focus on the standard or alternative therapy options for TC and the development of drug resistance in relation to CAF interaction in other tumor entities.

With FBs showing unique radioresistance themselves, it is no surprise that they promote radiotherapy resistance in tumors [162]. In colorectal cancer, Liu et al. showed an elevated radioresistance of cancer cells when pretreated with CAF CM. This effect was induced by exosomes of the CM activating the TGFβ1 signaling pathway [163]. The pancreatic stellate cells, a myofibroblast-like cell type, protected pancreatic adenocarcinoma cells against

radiation when the cells were co-cultured *in vitro* and *in vivo*. Hereby, the radioprotective mechanism was mediated via the β 1-integrin signaling in the tumor cells [164].

When looking into chemotherapeutic agents, several studies have shown an association between increased chemoresistance and CAF involvement. For instance, in ovarian cancer, it has been shown that tumor specific CAFs induced carboplatin resistance in the tumor cells. When CAFs were located in the proximity of the tumor cells, dedifferentiation of ovarian cancer cells to ovarian cancer stem cells by Wnt(5a)-signaling led to lower carboplatin sensitivity of the tumor [130]. Also, in vulvar squamous cell carcinoma, the *in vitro* co-cultivation with associated CAFs led to a lower carboplatin sensitivity in cancer cells [165].

Regarding etoposide as a component of the BEP treatment for TC, resistance effects induced by CAF were observed in neuroblastoma. Here, neuroblastoma cell lines were pre-cultivated in neuroblastoma-derived CAF CM and subsequently treated with etoposide. The CAF CM reduced the apoptotic effect when compared to treatment with skin nFB CM or tumor cell CM. The authors showed further that the acquired drug resistance of neuroblastoma cells was induced by the increased phosphorylation of STAT3 and ERK1 / 2 through the CAF CM treatment [166].

Considering cisplatin, lung mesothelioma activated CAFs 3D co-cultured with mesothelioma cells led to a lower response to cisplatin as the cancer cell viability were not reduced compared to single cultivation plus cisplatin treatment [167]. Moreover, in gastric cancer, Zhai et al. observed an increased positive staining for anti-IL8 in chemoresistance patient samples compared to chemosensitive patients. Hereby, CAF were the source of IL8 secretion. In fact, IL8 application in gastric cancer cell lines had a protective effect for the cell viability when additionally treated with cisplatin [168]. Also, in esophageal squamous cell carcinoma cells lines, the pre-treatment with CM of esophageal squamous cell carcinoma-derived CAFs and the xenografted co-cultivation of these cells decreased the tumor cells cisplatin and carboplatin sensitivity significantly via TGF β 1 signaling [169].

When the original TME cell composition does not yet result in a drug resistance itself, the drug application can ultimately affect the tumor composition and may support the resistance mechanisms subordinately. As seen in ovarian cancer by comparing the cell composition pre- and post-chemotherapy, higher amount of CAFs in the tumor tissue could be observed post-treatment [130]. Also, the application of sunitinib, a VEGFR inhibitor, increased the total number of CAF in renal cell carcinoma compared to samples of untreated patients. The authors also showed the decreased drug penetration through a CAF barrier leading to a lower concentration of sunitinib in cancer cell *in vitro* [131]. Sunitinib is one potential alternative treatment option for cisplatin refractory GCT patients [170]. Further, doxorubicin, applied as combination treatment with paclitaxel and cisplatin, has potential as salvage therapy for refractory GCT patients as well [171]. However, the study of Monteran

et al. showed the challenging interaction of doxorubicin and CAF. Firstly, systemic doxorubicin treatment modulated the stromal landscape in the lungs *in vivo*. The then activated lung CAFs supported the formation of a proinflammatory environment facilitating the implantation of breast cancer metastasis in the lungs. This might explain chemoresistance in the breast cancer patient setting [132].

So far, it is already known that the application of chemotherapy agents in TC patients can alter the stromal landscape. Bleomycin induces lung fibrosis in 3 - 40 % of the cases in TC [172]. Moreover, fibrotic residuals in the tumor side are commonly observed post-chemotherapy [173]. In the case of cisplatin treated patients with metastatic GCTs, 40 - 52 % of them are remaining with fibrotic (or necrotic) tissue residing in the retroperitoneal area [174].

Recapitulating, the development of chemo- and radiotherapy resistance is a double-edged sword as CAFs influence the tumor cell response to therapeutics, but therapeutics also alter the (tumor) stroma. Thus, the radio- or chemotherapy induced collateral tissue damage should be considered when treating cancer patients and deciphering the development of resistance. Targeting CAFs specifically has awakened interest in the scientific community and hence the current therapeutical approaches will be presented in the next chapter.

1.2.5 CAFs as a novel target for therapeutical strategies

Targeting cells of the TME have been proven to be efficacious as therapy option. Numerous clinical trials and several treatments have been approved by the *US Food and Drug Administration* (FDA), e.g., the most prominently known are immune checkpoint inhibitors [175]. As of today, various efforts have already been made to utilize CAFs as a specific target in cancer therapy [175,176]. The options range between the rather cell type unspecific inhibition of epigenetic modulators, inhibition of intracellular or extracellular signal transducer molecules, and remodeling the ECM structure, to more defined alternatives like DNA vaccines and various antibody or cell-based therapies against CAF specific surface markers in *in vitro* and *in vivo* studies. There is an astonishing amount of variation and variety of potential CAF therapy strategies. This chapter gives a comprehensive overview.

First, beginning with options interfering with the **chromatin structure**: the genetic depletion of epigenetic erasers, like the histone deacetylases (HDACs), in CAFs inhibited tumor growth when co-injected with murine pancreatic ductal adenocarcinoma cells. Further, the inhibition of HDACs with the small molecule Entinostat could minimize tumor progression and maximize survival in the pancreatic ductal adenocarcinoma mouse model [177]. *HDAC6* levels were upregulated in murine and human breast cancer originating CAFs compared to non-cancerous FB. Thus, treatment with the HDAC inhibitor ACY1215 reduced tumor growth

of murine xenografts of co-injected CAF and breast cancer cells by the impairment of the CAFs immunosuppressive properties [178]. But, the role of the pharmacological disruption of other epigenetic modulators in the activation of FB to CAF will be discussed further below. These therapy attempts with rather unspecific target structures like high expression levels of HDACs is also common in the tumor cells of various other cancers [179,180].

Further, the **intracellular signaling** has been proven to be a potential pharmacological target as Gagliano et al. showed upregulated PI3-Kinase C δ (PI3KC δ) expression in triple negative breast cancer-derived CAFs compared to the breast cancer cell lines. Since the pre-treatment of primary FB cell lines with the PI3KC δ inhibitors CAL-101 could reduce the invasiveness of triple negative breast cancer cell lines *in vitro* and the tumor volume *in vivo* [181].

Because of the resemblances between wound-healing FBs and CAFs, the use of fibrotic agents is also a convenient strategy in cancer therapy. Antifibrotic agents fall in the category of attacking the **extracellular signaling** e.g., drugs like pirfenidone. This drug is commonly used in lung fibrosis, induces apoptosis, and diminishes the TGF β 1 expression in lung cancer-derived CAFs [182]. Additionally, in a co-culture model with a non-small cell lung cancer cell line and CAFs, the combination treatment with pirfenidone and cisplatin induced higher levels of apoptosis than single treatment in both cell types. *In vivo* approaches validated the anti-tumor effect by reducing tumor growth in nude mice [183]. As pirfenidone attacks one communication point between cancer cells and CAFs, the cytokine TGF β , this fact was used in triple negative breast cancer 3D cell models with murine CAF by suppressing the tumor growth promoting effect of CAF via TGF β signaling interference [184].

As mentioned in **chapter 1.2.2**, many different CAF **markers** are identified and used as approach to eradicate CAF. While CAF-antigen specific antibodies successfully enrich in the tumor site and are useful for diagnostic reasons, the application for therapy seems inevitable. FAP is one of the best researched classifications (and diagnostic) markers for CAFs of many different tumor types. Thus, small molecule inhibitors targeting FAP have been developed, but, despite the reliability as marker, have not been as successful. Because the single application of the FAP inhibitor UAMC-1110 only delayed tumor growth but did not interfere with tumor progression in murine pancreatic adenocarcinoma models [185]. However, the usage as drug delivery target has been proven to be beneficial. The recent study of Liu et al., showed the druggability of CAF by tandem aiming of two CAF marker. In that case, FAP was used as antibody delivery target and PIN1 as drug target in a (DNA-barcoded) micellar system containing the PIN1 inhibitor AG17724. This led to successful inhibition of tumor growth in pancreatic cancer *in vitro* [186]. Other studies also showed the deployment of FAP as target for oncolytic adenovirus and their application reduced tumor growth significantly of

xenografted gastric carcinoma cells but neglecting the verification if the declined tumor growths were due to FAP⁺ CAF lysis and therefore antitumoral effect [187].

Correspondingly, other CAF specific markers are regularly used in therapy approaches. In the study of Su et al., CD10⁺ GPR77⁺ CAF subtypes, chosen because of their association with chemoresistance and poor survival in breast and lung cancer, were drugged with an anti-GPR77 antibody in combination with docetaxel. In patient-derived xenografts bearing breast tumors this led to apoptosis induction in both, CAFs and tumor cells, lower overall levels of CD10⁺ GPR77⁺ CAFs and re-establishment of chemo-sensitive tumors by neutralizing downstream effects of CAFs in breast cancer cells [188].

The use of antibodies as alternative cancer treatment is known as **immunotherapy**. The rising development of antibody-drug conjugates (ADC) has opened a new window for target specific cancer treatment and many ADCs have already been approved for clinical use [189]. It unites the selectivity of a monoclonal antibody for a specific protein and a coupled cytotoxic drug of choice [190]. Here, the combination of the separate elements for the coupled drug are manifold. This concept has already been modified to nanobody-drug (NDC) and antibody-photo absorber conjugates (APC). Subsequently, further subdivision depending on the linked drug (e.g., DNA intercalators / microtubules destabilizer) or the linker (pH-, glutathione- protease-sensitive or non-cleavable) can be made.

The classical variants of ADCs loaded with cytotoxic compounds like maytansine or monomethyl auristatin E (MMAE) targeting FAP⁺ CAFs in head and neck, lung, and pancreas carcinoma or targeting LRRC15⁺ CAFs in adenocarcinoma, breast tumors, and glioblastoma, had antitumoral effects, respectively [191,192]. Further, APCs targeting CAF had antiproliferative effect by firstly, application of PDPN-APC targeting PDPN⁺ CAF in xenografted murine oral tumors and secondly, irradiation with near-infrared light to subsequently induce cell death [193].

Finally, immunotherapy also comprises chimeric antigen receptor (CAR)-macrophage, -natural killer (NK), and -T cells [194]. These therapy approaches have already been implemented into CAF targeted research. The treatment with murine and human FAP primed CAR-T cells reduced tumor growth and extended the survival of mice injected intravenously with lung cancer cells compared to non-primed CAR-T cells and control treatment by directly eliminating FAP⁺ CAFs [195].

As previously mentioned, several studies have highlighted the importance of the microenvironment, especially FBs, in testis, GCT development and GCT drug resistance [112–116]. However, the data on CAFs in GCT is insufficient and with the important role of CAFs in other tumor entities, it is indispensable to investigate GCT-CAFs.

1.3 Aim of this thesis

Due to the responsiveness to cisplatin, type II GCT patients generally face a high curability compared to other cancers with a 5-year OS from 93 - 97 % [19,20]. Despite that, primarily young men in the middle of their lives at the ages of 15 - 54 years are affected and consequently confronted with life changing side effects like infertility and secondary malignancies by the chemotherapy [19,20,91]. As shown in numerous other cancer types, CAFs are involved in supporting the tumor cell growth and promoting chemotherapy resistances, are proven to be reliable diagnostic, predictive, and prognostic markers, and even serve as target in new therapeutical approaches [130,149,152,153,176]. In the case of GCTs, the application of chemotherapeutics has already been shown to modulate the stromal landscape leading to fibrotic residuals in the tumor [172–174]. Nevertheless, data on testicular FBs is limited and detailed analyses of CAFs within the context of GCTs are lacking [106,107]. Therefore, this thesis will comprehensively analyze GCT-derived CAFs for the first time by DNA methylation arrays, RNAseq, and MS-based proteome and secretome examination. The high throughput analyses will not only help with the determination of novel factors in the TME of GCTs in this thesis but will lay foundation for future studies.

In the following, specific research questions are described and illustrated in **Figure 4**:

Research questions:

- I. The establishment of GCT patient-derived *ex vivo* CAF cultures, including the collection and cultivation, will be fundamental for this work. Hence, the first question is whether the CAF cultures are of purely non-tumoral and fibroblastic cell origin.
- II. Secondly, how does the DNA methylome landscape of GCT-CAFs look like? Do GCT-CAFs present a particular transcriptional profile? Ultimately, what are certain proteins produced and secreted by GCT-CAFs? After successful isolation and confirmation of the CAF cultures, the high throughput data-based characterization will provide information on the influence of the tumor origin on the CAF characteristics. Therefore, the question is whether there are epigenetic, transcriptional, and translational differences between GCT-CAFs and nFBs. Further, are there even differences among SE- and NS- (EC- / TE-) derived CAF cultures?
- III. At a third level, which factors are most significantly deregulated in SE-, EC-, and TE-CAF in comparison to nFBs? The epigenetic and molecular characterization of GCT-CAF is expected to offer a basis for the identification of a potential soluble mediator in the communication between GCT cells and CAFs.

- IV. Lastly, what functional role do the identified factors play in the GCT context? Do the factors affect the proliferation of GCT cell lines and the expression of cisplatin sensitivity-related factors? What is their predictive potential?

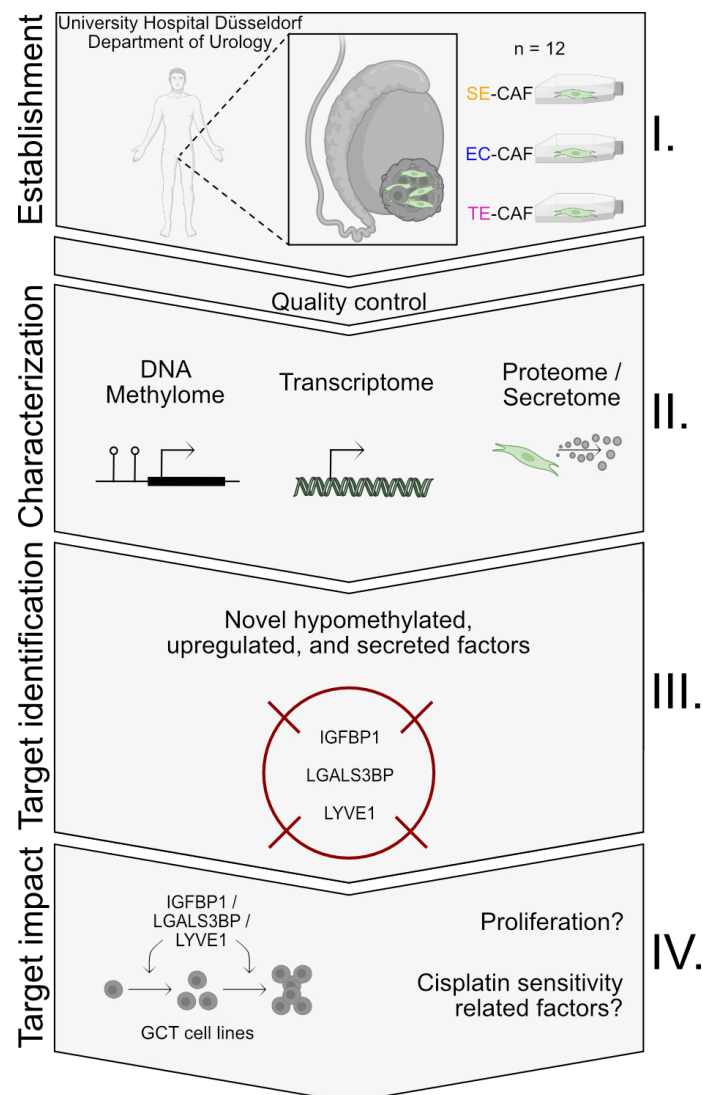


Figure 4: Illustration of the aim of this thesis.

Aim and workflow illustrated along the research questions I. - IV. shown as 'Establishment', 'Characterization', 'Target identification' and 'Target impact'. Partially created with BioRender.com by Alexa Stephan.

2 Materials and methods

2.1 Ethics vote

The positive vote by the ethics committee of the Medical Faculty of the *Heinrich Heine University Düsseldorf* (EC-HHU-D) for the usage of tumor tissues for *ex vivo* cultivation and CAF generation specific for this study (vote 2021-1746) is available. Additional positive vote of the EC-HHU-D for the cultivation of tumor cell lines (vote 2019-412), the consent information of each patient and approval of the EC-HHU-D for biobanking and researching tumor material (vote 4601) are available upon request.

2.2 Cell cultivation

2.2.1 Cell cultivation materials

Table 2: Cell (line) cultivation conditions.

CELL LINE	SPECIES	ORIGIN	MEDIUM	SUPPLEMENTS	COMPANY / KINDLY PROVIDED BY
TCam-2	Human	SE	RPMI	1 % P / S, 1 % L- glutamine, 10 % FBS	Dr. Janet Shipley (Institute of Cancer Research, Sutton, England)
2102EP		EC (testis)	DMEM		Dr. Christoph Oing (University Hospital Eppendorf, Hamburg, Germany)
NCCIT		EC (mediastinum)	RPMI		
NT2/D1		EC (testis)	DMEM		
JAR		CC	DMEM		
GCT72		YST	RPMI	ATCC, #HTB-144	Dr. Thomas Müller (University Clinic for Internal Medicine IV, Hematology / Oncology, Medical Faculty of Martin Luther University Halle-Wittenberg, Germany)
HUVEC		Endothelial (umbilical cord)	Endothelial Cell Growth Medium 2	Endothelial Cell Growth Medium Supplement	Prof. Dr. Gerhard Fritz, Institute of Toxicology, Medical Faculty, HHU, Düsseldorf, Germany)
MPAF		Fibroblast (Crista iliaca)	DMEM	1 % P / S, 1 % L- glutamine, 1 % NEAA, 100 µM β-mercapto- ethanol, 10 % FBS	Dr. Michael Peitz (Life & Brain, Department of Reconstructive Neurobiology, Bonn, Germany)
LB-C18m					
iLB-C1-30m					
LB-C35m					
LB-C2-36m					

Table 3: Materials and machines for cell cultivation, conservation, treatment, and counting as well as conditioned medium generation.

MATERIAL	COMPANY	LOCATION
Acrodisc MS syringe filter (0.2 µm)	Pall Corporation / cytiva	Dreieich, Germany
Automated Cell Counter TC20	Bio-Rad Laboratories	Feldkirchen, Germany
Cell Counting Slides for TC20	Bio-Rad Laboratories	Feldkirchen, Germany
Cell culture bench Scanlaf Mars	LaboGene	Kopenhagen, Denmark
Cell culture dish (6-, 96-well-plates, 100 mm, 145 cm ²)	Greiner Bio One	Frickenhausen, Germany
Cell scraper	Sarstedt	Nümbrecht, Germany
Centrifuge 5810 R	Eppendorf	Hamburg, Germany
Conical bottom tubes (15 mL, 50 mL)	Greiner Bio One	Frickenhausen, Germany
Couling centrifuge Allegra	Beckmann Coulter Life	Krefeld, Germany
CO ₂ -Incubator HeraCell 150i	Thermo Fisher Scientific	Schwerte, Germany
CryoTube Vials (1 mL)	Thermo Fisher Scientific	Schwerte, Germany
Dimethyl sulfoxide (DMSO)	Sigma-Aldrich / MERCK	Taufkirchen, Germany
Dulbecco's Phosphate Buffered Saline (PBS)	Sigma-Aldrich / MERCK	Taufkirchen, Germany
DMEM (1 x) + GlutaMAX-I, [+] 4.5 g / l D-Glucose, [+] Pyruvate	Gibco / Thermo Fisher Scientific	Schwerte, Germany
DSG2 (recombinant protein, 947-DM)	R & D Systems	Wiesbaden-Nordenstadt, Germany
Endothelial Cell Growth Medium 2	Promocell	Heidelberg, Germany
Endothelial Cell Growth Medium Supplement	Promocell	Heidelberg, Germany
Eppendorf tubes (0.5 mL, 1.5 mL, 2 mL)	Eppendorf	Hamburg, Germany
Fetale bovine serum (FBS)	Bichrom / MERCK	Darmstadt, Germany
Filter-pipette tips 10 µL, 100 µL, 1000 µL	Greiner Bio One	Frickenhausen, Germany
GNS (recombinant protein, 2484-SUC)	R & D Systems	Wiesbaden-Nordenstadt, Germany
RS225 Cabinet irradiator (x-rays)	Gulmay	Werne, Germany
IGFBP1 (recombinant protein, 871-B1-025)	R & D Systems	Wiesbaden-Nordenstadt, Germany
LGALS3BP (recombinant protein, 2226-GAB)	R & D Systems	Wiesbaden-Nordenstadt, Germany
LYVE1 (recombinant protein, 2089-LY)	R & D Systems	Wiesbaden-Nordenstadt, Germany
L-glutamine (200 mM, 100 x)	Gibco / Thermo Fisher Scientific	Schwerte, Germany
MiniSpin mini centrifuge	Eppendorf	Hamburg, Germany
Neubauer Counting Chamber	VWR Chemicals	Darmstadt, Germany
Non-essential amino acids MEM NEAA (100 x)	Gibco / Thermo Fisher Scientific	Schwerte, Germany
Penicillin / streptomycin (P / S) (10000 U)	Gibco / Thermo Fisher Scientific	Schwerte, Germany
Pipette tips (10 µL, 100 µL, 1000 µL)	Nerbe	Winsen / Luhe, Germany
Pipettes (2.5 µL, 20 µL, 100 µL, 200 µL, 1000 µL)	Eppendorf	Hamburg, Germany
Pipetting controller	Hirschmann Laborgeräte	Eberstadt, Germany
PLOD3 (recombinant protein, 16193142)	Thermo Fisher Scientific	Schwerte, Germany
Reaction tubes (0.5 mL, 1.5 mL, 2.0 mL)	Eppendorf	Hamburg, Germany
RPMI 1640 (1 x), [-] L-glutamine	Gibco / Thermo Fisher Scientific	Schwerte, Germany
Scalpel	Thermo Fisher Scientific	Schwerte, Germany
Soda-lime-silica glass Pasteur pipettes	Brand	Wertheim, Germany
Stripette (2 mL, 5 mL, 10 mL, 25 mL)	Corning	Kaiserslauten, Germany
Syringe Omnix Luer Lock Solo (10 mL)	B. Braun Melsungen AG	Melsungen, Germany
T25-, T75-flasks	CELLSTAR / Greiner	Frickenhausen, Germany
Trypan blue 0.4 %	Sigma-Aldrich / MERCK	Taufkirchen, Germany
Trypsin-EDTA 0.05 %	Gibco / Thermo Fisher Scientific	Schwerte, Germany
TS2 Inverted Routine Microscope	Nikon Instruments	Düsseldorf, Germany
β-mercaptoethanol	Sigma-Aldrich / MERCK	Taufkirchen, Germany

2.2.2 General cell culture conditions

The adherent, malignant GCT cell lines (TCam-2 (SE); 2102EP, NCCIT, NT2/D1 (EC), JAR (CC), and GCT72 (YST)), endothelial cell line (HUVEC) and primary FB cultures were cultivated in T25 or T75 flasks in *Roswell Park Memorial Institute 1640 medium* (RPMI) or *Dulbecco's Modified Eagles Medium* (DMEM), respectively. The medium was supplemented with 1 % penicillin / streptomycin (P / S), 1 % L-glutamine, 10 % fetal bovine serum (FBS), and, for FB cultivation, additionally with 1 % non-essential amino acids (NEAA)

and 100 μ M β -mercaptoethanol (**Table 2**). For subsequent cultivation, the cells were dissociated once (FB) or twice (GCT cell lines) per week when reaching 80 - 90 % confluency by washing thoroughly with phosphate buffered saline (PBS) and detaching by trypsinization with 0.05 % trypsin-EDTA at 37 °C and 7.5 % CO₂. The enzymatic digestion was stopped by adding the twofold of appropriate medium and a suitable amount of cell suspension was added to fresh medium. The cell lines were incubated at 37 °C and 7.5 % CO₂. For calculation of cell counts, a 1 : 2 dilution with trypan blue were prepared and measured by the automated Cell Counter TC20 (see **Table 3** for materials). For authentication short tandem repeats (STR-) profiles were determined and are available upon request. Cell lines were tested regularly for mycoplasma contamination.

2.2.3 CAF isolation and cultivation

Freshly dissected *ex vivo* tumor samples from patients with testicular SE and NS tumors were directly used for FB isolation, in this study labelled as CAF (**Table S1**). For transport, tumor samples were placed into RPMI medium (+ 1 % P / S, 1 % L-glutamine, 10 % FBS) on ice for 15 minutes (min). Subsequently, the tumor samples were roughly cut into 1 x 1 cm³ pieces by using a scalpel. Then, the smaller tumor parts were further mechanically disaggregated with a glass Pasteur pipette. The tumor parts, the medium in which the disaggregation took place, and fresh medium were transferred into a T75 flask. For initial attachment and growth, RPMI medium (+ 1 % P / S, 1 % L-glutamine, 10 % FBS) was used. After 1 - 2 weeks, the medium was exchanged to DMEM (+ 1 % P / S, 1 % L-glutamine, 1 % NEAA, 100 μ M β -mercaptoethanol, 10 % FBS) and served from then on as standard medium. FBs were subcultivated once per week (see **chapter 2.2.2** for procedure and **Table 3** for materials).

2.2.4 Cryo conservation

For long term storage of cell lines and primary cells, cells of low passages were harvested by trypsinization and centrifuged at 99 x g, at room temperature (RT) for 5 min. The supernatant was discarded, the cell pellet resuspended with FBS (+ 10 % DMSO) and partially transferred into cryo tubes. These tubes were immediately cryo conserved. For the thawing procedure, frozen cells were quickly dissolved by adding cell specific medium and transferring the cell solution into a T75 flask with additional 15 mL of fresh cell specific medium. After 24 hours (h), cell viability was checked by microscope and the medium was exchanged (see **Table 3** for materials).

2.2.5 Generation of CM

To produce CM of nFB and CAF for secretome analysis (**chapter 2.5.5**), two confluent T75 flask of CAF were seeded into a 145 cm²-dish and incubated for 24 h in standard FB medium. Thereafter, cells were washed thoroughly seven times with PBS and fresh supplement-free DMEM medium was added. After another 24 h, the supernatant and cells were collected. For this step, the CM was processed through a 0.2 µm filter, centrifuged at 1000 x g, 4 °C for 5 min, transferred to a new tube and stored at - 80 °C. The cellular fraction was placed immediately on ice, washed twice with PBS, and harvested by cell scraping. Next, the cells were centrifuged at 800 x g, 4 °C for 5 min, the supernatant was discarded, and the cell pellet was stored at - 80 °C. To produce CM of nFB and CAF for treatment of cancer cell lines 1.5 x 10⁶ cells per 145 cm² dish were seeded and irradiated with 10 Gy. After the first 24 h, the medium was discarded and thereafter collected daily for 72 h and stored at - 80 °C (see **Table 3** for materials).

Cell viability was controlled via observation by microscope (pre- and post-washing step, pre-collecting step). All CM samples of CAFs were prepared as replicates, one for internal procedure control and one for MS analysis.

2.2.6 Cell treatment with CM or recombinant proteins

In the case of cell treatment, 90'000 cells / 6-well of MPAF (nFB) were treated daily with 100 ng / mL recombinant proteins of DSG2, GNS, and / or PLOD3 for 72 h, whereby the cells were harvested 24 h after the last treatment and further processed as described in **chapter 2.4.2**. SE and EC cell lines were treated daily with 10 or 100 ng / mL of IGFBP1, LGALS3BP or LYVE1 or with CM of nFB or CAF (70 : 30, CM : fresh medium) over 10 days (d) for either continuous cell counting as described in **chapter 2.2.7** or following the 10 d treatment further processed as described in **chapter 2.4.2** (see **Table 3** for materials).

2.2.7 Proliferation assay

The proliferation rate was assessed by cell counting every second day over the period of 10 d. Therefore, TCam-2 (1300 cells / 24-well) and 2102EP, NCCIT, and NT2/D1 (2650 cells / 24-well) cells were seeded, treated daily (as described in **chapter 2.2.6**) and counted every second day using a Neubauer counting chamber (see **Table 3** for materials).

2.3 DNA isolation and analysis

2.3.1 DNA isolation and analysis materials

Table 4: Materials and machines for DNA precipitation, purity validation and analysis.

MATERIAL	COMPANY	LOCATION
Agarose minigel electrophoresis system Easy-Cast	Owl Scientific / Thermo Fisher Scientific	Schwerte, Germany
DNA loading dye (6 x, purple)	New England Biolabs	Frankfurt am Main, Germany
EDTA solution (pH 8; 0.5 M)	PanReac AppliChem / ITW Reagents	Darmstadt, Germany
Ethanol (70 %; 96 %, absolute)	VWR Chemicals	Darmstadt, Germany
Gel documentation system	INTAS	Göttingen, Germany
GeneRuler 1 kb DNA ladder	New England Biolabs	Frankfurt am Main, Germany
Hydrochloric acid (HCl) (1.5 %; 0.5 M)	Carl Roth	Karlsruhe, Germany
HulaMixer	Invitrogen / Thermo Fisher Scientific	Schwerte, Germany
Microprocessor pH Meter	WTW	Weilheim, Germany
Microwave	Küppersbusch	Gelsenkirchen, Germany
MiniSpin mini centrifuge	Eppendorf	Hamburg, Germany
NanoDrop 2000 / 2000c	Thermo Fisher Scientific	Schwerte, Germany
NanoDrop 2000 V 1.6	Thermo Fisher Scientific	Schwerte, Germany
Power Pack P25	Biometra	Göttingen, Germany
Proteinase K	Carl Roth	Karlsruhe, Germany
RNase A	Qiagen	Hilden, Germany
Rotiphenol (phenol / chloroform / isoamyl alcohol (PCI))	Carl Roth	Karlsruhe, Germany
Rotiphorese TAE buffer (50 x)	Carl Roth	Karlsruhe, Germany
Sodium acetate (C ₂ H ₃ NaO ₂)	MERCK	Taufkirchen, Germany
Sodium chloride (NaCl)	MERCK	Taufkirchen, Germany
Sodium dodecyl sulfate (SDS)	Carl Roth	Karlsruhe, Germany
SYBR-Safe, DNA Gel stain	Invitrogen / Thermo Fisher Scientific	Schwerte, Germany
TE buffer	PanReac AppliChem / ITW Reagents	Darmstadt, Germany
Tris (C ₄ H ₁₁ NO ₃)	VWR Chemicals	Darmstadt, Germany
Thermomixer 5436	Eppendorf	Hamburg, Germany
UV-table FLX 20 M	Vilber Lourmat	Eberhardzell, Germany

2.3.2 DNA precipitation

DNA was isolated from cell pellets via phenol / chloroform / isoamyl alcohol (PCI) extraction. Briefly, after cell trypsinization and pelletization by centrifugation (99 x g, 5 min, RT), 300 µL extraction buffer (100 mM NaCl, 10 mM Tris-HCl (pH 8), 25 mM EDTA (pH 8)), 40 µL sodium dodecyl sulfate (SDS) (10 %), RNase A (final concentration of 0.1 mg / mL)) were added and incubated at RT for 10 min, followed by incubation with 12.5 µL proteinase K (10 mg / mL) for 5 min at RT. Then, 360 µL PCI were added, homogenized for 10 min, and centrifuged for 10'000 x g, 4 °C for 20 min. The upper aqueous phase was cautiously transferred to a new tube. For precipitation, 1 : 10 of the supernatant's volume of 3 M sodium acetate (pH 5.2) and three times 100 % ethanol were added and inverted. For purification of DNA, 70 % ethanol addition and centrifugation (13'000 x g, RT, 5 min) were repeated twice, the pellet was airdried, and dissolved in TE buffer at 55 °C for 1 h. Purity and concentration were determined spectrophotometrically by calculating the 260 / 280 and 260 / 230 nm ratios with the NanoDrop 2000. DNA was stored at 4 °C (see **Table 4** for materials).

2.3.3 Agarose gel electrophoresis

For confirmation of DNA purification, DNA was checked via agarose gel electrophoresis. Therefore, agarose was dissolved in 1 x TAE-buffer in double-distilled (dd)H₂O to an end concentration of 1.5 %, and 1 : 50'000 DNA gel stain was added. 100 ng DNA was mixed with 1 x gel loading dye, samples and a DNA ladder were loaded into the wells of the agarose gel and run at 75 V (see **Table 4** for materials).

2.3.4 Illumina 850k DNA methylation assay

For DNA methylome analysis, DNA samples of nFB (n = 5) and CAF cultures (SE-CAF = 6, NS-CAF: EC-CAF = 3 and TE-CAF = 3) were prepared as described in **chapter 2.3.2**. Analysis via Illumina 850k DNA methylation assay and basic statistical bioinformatics have been performed by the cooperation partners Dr. med. Catena Kresbach and Prof. Dr. med. Ulrich Schüller (*Institute of Neuropathology*, University Hospital Hamburg-Eppendorf, Hamburg, Germany) and Dr. rer. nat. Wasco Wruck and Prof. Dr. James Adjaye (*Institute for Stem cell Research and Regenerative Medicine*, University Hospital Düsseldorf, Düsseldorf, Germany):

Briefly, 100 - 500 ng DNA were used for bisulfite conversion with the *EZ DNA Methylation Kit* (Zymo Research). Afterwards, the *DNA Clean & Concentrator-5* (Zymo Research) and the *Infinium HD FFPE DNA Restore Kit* (Illumina) were used to clean and restore the converted DNA. Finally, the *Infinium 850k MethylationEPIC BeadChip* (Illumina) was used to evaluate the methylation status of 850'000 CpG sites on an *iScan* device (Illumina).

2.4 RNA isolation and analysis

2.4.1 RNA isolation and analysis materials

Table 5: Materials and machines for RNA isolation, subsequent cDNA synthesis, qRT-PCR analysis and RNAseq.

MATERIAL	COMPANY	LOCATION
CFX Maestro Software	Bio-Rad Laboratories	Feldkirchen, Germany
CFX384 Touch Thermal Cycler	Bio-Rad Laboratories	Feldkirchen, Germany
dNTP Mix (10 mM)	Thermo Fisher Scientific	Schwerte, Germany
Ethanol (70 %; 96 %, absolute)	VWR Chemicals	Darmstadt, Germany
Framestar 384 Well Skirted PCR Plate	4titude von Brooks Life Sciences	Griesheim, Germany
Luna Universal qPCR Master Mix	New England Biolabs	Frankfurt am Main, Germany
Maxima H Minus Reverse Transcriptase (200 U / μ L)	Thermo Fisher Scientific	Schwerte, Germany
MiniSpin mini centrifuge	Eppendorf	Hamburg, Germany
MyFuge Mini PCR tube Centrifuge	Benchmark Scientific / Biozym,	Hessisch Oldendorf, Germany
NanoDrop 2000 / 2000c	Thermo Fisher Scientific	Schwerte, Germany
NanoDrop 2000 V 1.6	Thermo Fisher Scientific	Schwerte, Germany
Oligo(dT) ₁₈ -Primer (0.5 μ g / μ L)	Thermo Fisher Scientific	Schwerte, Germany
PCR Reaction type 8 stripes Multiply μ Strip Pro	Sarstedt	Nümbrecht, Germany
RiboLock RNase Inhibitor (40 U / μ L)	Thermo Fisher Scientific	Schwerte, Germany
RNeasy Mini Kit	Qiagen	Hilden, Germany
RT Puffer (5 x)	Thermo Fisher Scientific	Schwerte, Germany
Sigma H ₂ O (RNase free)	Sigma-Aldrich / MERCK	Taufkirchen, Germany
S100 Thermal Cycler	Bio-Rad Laboratories	Feldkirchen, Germany
β -mercaptoethanol	Sigma-Aldrich / MERCK	Taufkirchen, Germany

2.4.2 RNA isolation

For quantitative real time (qRT-) polymerase chain reaction (PCR) analyses, total RNA was isolated through the *RNeasy Mini Kit* by Qiagen via spin column technology according to the manufactures protocol [196]. Briefly, after lysis and homogenesis of cells, the cell lysate is added to a spin column with a silica membrane providing ideal binding conditions for RNA. Following several washing steps, purified RNA was eluted in 30 μ L Sigma H₂O. The purity and concentration were evaluated spectrophotometrically by determining the 260 / 280 and 260 / 230 nm ratios with the NanoDrop 2000 (see **Table 5** for materials). RNA samples were stored at - 20 °C.

2.4.3 Reverse transcription for cDNA synthesis

For cDNA synthesis, 1 μ g RNA was used for reverse transcription. Therefore, the volume of the required RNA was adjusted with Sigma H₂O to a volume of 12.5 μ L, and 1 μ L dNTP Mix, 1 μ L Oligo(dT)₁₈-Primer, 4 μ L RT buffer (5 x), 0.5 μ L RiboLock RNase Inhibitor, and 1 μ L Maxima H Minus Reverse Transcriptase were added per sample (total volume of 20 μ L per sample). The synthesis was run with the cycler program settings as described in **Table 6**. cDNA was diluted 1 : 17 (19 μ L transcribed cDNA sample and 304 μ L Sigma H₂O) and stored at - 20 °C (see **Table 5** for materials).

Table 6: Thermal cycler program settings for cDNA synthesis.

CYCLES	TEMPERATURE	DURATION
1 x	50 °C	5 min
1 x	85 °C	30 min
	4 °C	∞

2.4.4 qRT-PCR analysis

For gene expression and isochromosome i(12p) status analysis, qRT-PCR was utilized. By using suitable oligonucleotide sequences, the cDNA / genomic DNA of the transcripts listed in **Table 7** were amplified. Therefore, 7.74 ng of cDNA (8.5 µL of prepared dilution) or 3.68 ng genomic DNA (adjusted to a volume of 8.5 µL with Sigma H₂O), 7.5 µL Luna Universal qPCR Master Mix, 0.5 µL complementary and 0.5 µL reverse oligonucleotide sequences (both 10 µM) were mixed to analyze every sample as technical triplicates (5 µL / 384-well) (see **Table 5** for materials). For program settings of the CFX384 Touch Thermal Cycler see **Table 8**. For data normalization, for every sample (cell line or treatment) two housekeeper genes (*ACTB* and *GAPDH*) were amplified, and the averaged cycle threshold (Ct-) value of all triplicates of both genes was calculated. This average was used as reference for the calculation of the Δ Ct-values. For the calculation of expression differences, treated samples were normalized to the untreated control ($\Delta\Delta$ Ct-value) and the 'fold change' was determined [197]:

1. step: Δ Ct = Ct (target gene) - Ct (Housekeeper genes average)
2. step: $\Delta\Delta$ Ct = Δ Ct (treated) - Δ Ct (untreated)
3. step: 'fold change' = $2^{-(\Delta\Delta\text{Ct})}$

Table 7: Oligonucleotide sequences for gene expression and isochromosome i(12p) status analysis.

	GENE	FORWARD PRIMER (5'-3')	REVERSE PRIMER (5'-3')	°C	CYCLES
qRT-PCR	ACTA2/ α SMA	GTGTTGCCCTGAAGAGCAT	GCTGGGACATTGAAAGTCTCA	60	45
	ACTB	AAAGACCTGTACGCCAACAC	GTCATACTCCTGCTTGCTGAT	60	45
	ANG1	CTGGGCGTTTTGTTGTTGGTC	GGTTTGGCATCATAGTGCTGG	60	45
	ARG1	TGGACAGACTAGGAATTGGCA	CCAGTCCGTCAACATCAAAACT	60	45
	BCL2	CCTGTGGATGACTGAGTACCTG	CAGAGGCCGCATGCTGGG	60	45
	BCLXL	TAAACTGGGGTTCGATTGTG	AGGTAAGTGGCCATCCAAGC	60	45
	BIRC5	AGGACCACCGCATCTCTACAT	AAGTCTGGCTCGTTCTCAGTG	60	45
	BST2	ACCATAAGCTTCAGGACGCG	CCAGCAGCACAATCAGCAG	60	45
	CD74	CCGGCTGGACAACTGACA	GGTGCATCACATGGTCCTCTG	60	45
	CTR1	GGGGATGAGCTATATGGACTCC	TCACCAAACCGGAAAACAGTAG	60	45
	CXCL12	ATTCTCAACTCCAACTGTGC	ACTTTAGCTTCGGGTCAATGC	60	45
	EGFLAM	ACCATAAGCTTCAGGACGCG	CCAGCAGCACAATCAGCAG	60	45
	ERBB2	CCAGCTGGCTCTCACACTG	AGCCCTTACACATCGGAGAAC	60	45
	ERCC2	GTCGATGGGAAATGCCACAG	GTCATCCAGTTGTAGATGCC	60	45
	FAP	TGAACGAGTATGTTTGACAGTGG	GGTCTTTGGACAATCCCATGT	60	45
	FN1	CGGTGGCTGTCAGTCAAAG	AAACCTCGGCTTCTCCATAA	60	45
	FOXA2	TACGTGTTTCATGCCGTTTCAT	CGACTGGAGCAGCTACTATGC	60	45
	GAPDH	TGCCAAATATGATGACATCAAGAA	GAGTGGGTGTCGCTGTTG	60	45
	GAL	CTGGTGAGGCCATTCTTGTG	AAGGAAAAACGAGGCTGGAC	60	45
	GATA3	TCATTAAGCCCAAGCGAAGG	GTCCCCATTGGCATTCCCTC	60	45
	GDF3	CAGGAGGAAGCTTGGGAAAT	TGCTACGTAAAGGAGCTGGG	60	45
	GSR	TTCCAGAATACCAACGTCAAAGG	GTTTTTCGGCCAGCAGCTATTG	60	45
	GSTP1	CCCTACACCGTGGTCTATTTCC	CAGGAGGCTTTGAGTGAGC	60	45
	HTR2B	TCTTTTCAACCGCATCCATCA	TGCTGTAGCCCGTGAGTTATATT	60	45
	IGFBP1	TTGGGACGCCATCAGTACCTA	TTGGCTAAACTCTCTACGACTCT	60	45
	IL6	ACTCACCTCTTCAGAACGAATTG	CCATCTTTGGAAGGTTTCAGGTTG	60	45
	IL8	TTTTGCCAAGGAGTGCTAAAGA	AACCCTCTGCACCCAGTTTTTC	60	45
	LGALS3BP	CTGTGGGACCTGACTGATGC	CTCTTCAGCCAGCCCCAGG	60	45
	LYVE1	AGTGCTTGCTCTCCTCTTCT	TGCTATCATTGGCCTTCTCCTC	60	45
	MERTK	GTGCAGCGTTTCAGACAATGG	TGACAGGTGAGGTTGAAGGC	60	45
	MLH1	CTCTTCATCAACCATCGTCTGG	GCAAATAGGCTGCATACACTGTT	60	45
	MRP2	CCCTGCTGTTTCGATATACCAATC	TCGAGAGAATCCAGAATAGGGAC	60	45
	MSH2	AGGCATCCAAGGAGAATGATTG	GGAATCCACATACCCAACCTCCAA	60	45
	NANOG	GATTTGTGGGCCTGAAGAAA	CAAAGGCAAAACAACCCACTT	60	45
	PDGFRA	TTGAAGGCAGGCACATTTACA	GCGACAAGGTATAATGGCAGAAT	60	45
	PDPN	AACCAGCGAAGACCGCTATAA	CGAATGCCTGTTACACTGTTGA	60	45
	PEAR1	AAATGGAGGTGTCTTCCAAACC	CCCAGTGAATCGGTCACAGA	60	45
	PECAM1	ACCGTGACGGAATCCTTCTCT	GCTGGACTCCACTTTGCAC	60	45
	POLH	CTGGCACAAGTTCGTGAGTC	GCAACAAGTCTGCCGAGATAG	60	45
	POU5F1	CGAAAGAGAAAGCGAACCAG	GCCGGTTACAGAACCACACT	60	45
	PRAME	CGTAGACTCCTCCTCTCCACAT	TGGGCGATATACTGCTCTTCT	60	45
	REV1	GATGGAGGAAGCGAGCTGAAA	CCTTCTGCATAGCAGCATCTG	60	45
	REV3L	GTGGATGCTGTAGCTGCTGAT	ATGGCCTGTAGACCAGGGTTT	60	45
	S100A4	GGGCAAAGAGGGTGACAAGT	GAAGTCCACCTCGTTGTCCC	60	45
	SOX2	ATGCACCGCTACGACGRGA	CTTTTGACCCCTCCATT	60	45
	SOX17	GGCGCAGCAGAATCCAGA	CCACGACTTGCCAGCAT	60	45
	TNF α	GAGGCCAAGCCCTGGTATG	CGGGCCGATTGATCTCAGC	60	45
	TP53	CAGCACATGACGGAGGTTGT	TCATCCAAATACTCCACACGC	60	45
	VIM	AGTCCACTGAGTACCGAGAGAC	CATTCACGCATCTGGCGTTC	60	45
i(12p)	P1	GGCCTTCTTGCAACATGAGAGTAAG	CAGATGCACAAAAGGATGGCC	60	45
	P2	GCTCTGTGCGCCTCCATGTCAG	GTCTCTGTGTGCTCTCCTGGC	60	45
	P3	CATGCACTTCCCGCCCTTTTCC	ACTGACAGCTATCTCGCAGACCAAC	60	45
	P4	CTGGGATCTTGACACTCAGGACAC	TATGTGCCCTTAGACCAGGCAACTG	60	45
	P5	CCTATATCCCCTCTGCCACCAACAC	ACCTCTGCCATGAGAGGCAGTCTTT	60	45
	P6	AGGAAACCTTTGAGAGGCACAGTCG	CCGGGCAATCGCAATAGAGTGTAG	60	45
	P7	CACAGAGTAAAGGCCCGTGACTTT	ACAGAAGGGCCAGAAAAGAACCGAAC	60	45
	P8	TGGGCAGCCCTCATTATCTGGGGCA	ATCCACCCGCCATTGGCATCGAAGC	60	45

Table 8: Thermal cycler program settings for gene expression and isochromosome i(12p) status analysis.

CYCLES	TEMPERATURE	DURATION
1 x	95 °C	5 min
39 x	95 °C	30 min
	60 °C	
	Measurement	
	95 °C	
Melting curve	95 - 65 °C in 0.5 °C steps	5 s
	Measurement	

2.4.5 RNAseq

For transcriptome analyses, RNA samples of nFB (n = 5) and CAF cultures (SE-CAF = 6, NS-CAF: EC-CAF = 3 and TE-CAF = 3) were prepared as described in **chapter 2.4.2**. RNAseq and basic statistical bioinformatics have been performed by Dr. rer. nat. Patrick Petzsch at the ‘Core Facility: Genomics & Transcriptomics’ of Prof. Dr. rer. nat. Karl Köhrer of the HHU-D as described in the following protocol:

RNA samples were quantified by the *Qubit RNA HS Assay* (Thermo Fisher Scientific), and quality was determined by capillary electrophoresis using the *Fragment Analyzer*, and the *Total RNA Standard Sensitivity Assay* (Agilent Technologies). RNA samples with an integrity number of > 9 were used. The library preparation was performed according to the manufacturer’s protocol using the *VAHTS™ Stranded mRNA-Seq Library Prep Kit* for Illumina. Briefly, 500 ng total RNA was used as input for mRNA capturing, fragmentation, the synthesis of cDNA, adapter ligation and library amplification. Bead purified libraries were normalized and finally sequenced on the *NextSeq2000 system* (Illumina Inc.) with a read setup of 1 x 100 bp. The *BCL Convert Tool* (version 3.8.4) was used to convert the bcl files to fastq files as well for adapter trimming and demultiplexing. For statistical data analyses on fastq files were conducted with *CLC Genomics Workbench* (version 22.0.2, Qiagen). The reads of all probes were adapter trimmed (Illumina TruSeq) and quality trimmed (using the default parameters: bases below Q13 were trimmed from the end of the reads, ambiguous nucleotides maximal 2). Mapping was done against the *Homo sapiens* (hg38; GRCh38.88) (May 25, 2017) genome sequence. After grouping of samples, the statistical differential expression was determined using the *CLC Differential Expression for RNAseq tool* (version 2.6, Qiagen). The resulting *P* was corrected for multiple testing by FDR. *P* < 0.05 was considered significant.

2.5 Protein isolation and analysis

2.5.1 Protein isolation and analysis materials

Table 9: Materials and machines for protein precipitation, separation, visualization, and analysis.

MATERIAL	COMPANY	LOCATION
Acetic acid	MERCK	Taufkirchen, Germany
Acetone	VWR Chemicals	Darmstadt, Germany
Acrylamide 30 % (37, 5 : 1) Rotiphorese Gel 30	Carl Roth	Karlsruhe, Germany
Ammonium persulfate (APS)	Sigma-Aldrich / MERCK	Taufkirchen, Germany
Bovine serum albumin (BSA),	Pan-Biotech	Aidenbach, Germany
Centrifuge 5810 R	Eppendorf	Hamburg, Germany
Corning Costar Reagent reservoir	Corning	Kaiserslauten, Germany
ChemiDoc Imaging System	Bio-Rad Laboratories	Feldkirchen, Germany
Centrifuge Allegra	Beckmann Coulter Life	Krefeld, Germany
DAPI	Sigma-Aldrich / MERCK	Taufkirchen, Germany
Ethanol (70 %; 96 %, absolute)	VWR Chemicals	Darmstadt, Germany
Formaldehyde (37 %)	MERCK	Taufkirchen, Germany
Gyratory rocker SSL3	Stuart / BioCote / Carl Roth	Karlsruhe, Germany
Human LGALS3BP ELISA Kit	Proteintech	München, Germany
iMark Microplate Absorbance Reader	Bio-Rad Laboratories	Feldkirchen, Germany
Microprocessor pH Meter	WTW	Weilheim, Germany
Mini-Protean Tetra Cell system	Bio-Rad Laboratories	Feldkirchen, Germany
Multi-channel pipette	Eppendorf	Hamburg, Germany
Multi-channel pipette Xplorer plus	Eppendorf	Hamburg, Germany
N-lauroylsarcosine sodium (SLS)	MERCK	Taufkirchen, Germany
Page Ruler prestained protein ladder	Thermo Fisher Scientific	Schwerte, Germany
Pierce Silver Staining Kit	Thermo Fisher Scientific	Schwerte, Germany
PowerPac Basic Power Supply	Bio-Rad Laboratories	Feldkirchen, Germany
Sodium dodecyl sulfate (SDS)	Carl Roth	Karlsruhe, Germany
Sigma H ₂ O (RNase free)	Sigma-Aldrich / MERCK	Taufkirchen, Germany
Tetramethylethylenediamine (TEMED)	Sigma-Aldrich / MERCK	Taufkirchen, Germany
Thiourea	Sigma-Aldrich / MERCK	Taufkirchen, Germany
Trichloroacetic acid (TCA)	Carl Roth	Karlsruhe, Germany
Thermomixer 5436	Eppendorf	Hamburg, Germany
Tris (C ₄ H ₁₁ NO ₃)	VWR Chemicals	Darmstadt, Germany
Tris / glycine / SDS blotting buffer (10 x)	Miltenyi Biotech	Bergisch Gladbach, Germany
Triton X-100	Sigma-Aldrich / MERCK	Taufkirchen, Germany
Urea	VWR Chemicals	Darmstadt, Germany
Vortex-Genie 2	Scientific Industries / Thermo Fisher Scientific	Schwerte, Germany
White tray for ChemiDoc Imaging System	Bio-Rad Laboratories	Feldkirchen, Germany
3-((3-Cholamidopropyl) dimethylammonio)-1-propanesulfonat (CHAPS)	Carl Roth	Karlsruhe, Germany

2.5.2 Protein precipitation from CM

For internal quality control, every collected CM was checked for purity. Of each CM 5 mL was thawed cautiously on ice, N-lauroylsarcosine sodium (SLS) in PBS was added to an end concentration of 0.1 % (v / v) and well mixed by inverting. A quarter of the total volume of trichloroacetic acid (TCA) buffer (stock: 50 % (w / v) solution) was added, vortexed, and the then cloudy solution was incubated for 1 h on ice. Subsequently, the CM was centrifuged at 4225 x g (swinging bucket / rotor), 4 °C for 10 min, and the supernatant was discarded. The precipitated protein pellet was washed twice by adding 1 mL ice cold acetone, vortexing and centrifuging at 10'000 x g, 4 °C for 10 min. The pellet was then shortly dried at 37 °C and diluted in 50 µL urea buffer (30 mM Tris base (1 M), 2 M thiourea (76.12 g / mol), 7 M urea (121.14 g / mol), and 4 % (w / v) 3-((3-Cholamidopropyl)

dimethylammonio)-1-propansulfonat) (CHAPS) (pH 8.5) in water) (see **Table 9** for materials). Proteins were stored at - 20 °C.

2.5.3 Protein separation via sodium dodecyl sulfate polyacrylamide gel electrophoresis

As the protein isolation from CM, separation via SDS-polyacrylamide gel electrophoresis (PAGE), and visualization via silver staining served as internal quality control, the exact protein concentration was not determined but different volumes and serial dilutions of the protein solution were used (15 µL, 10 µL, 5 µL, 1 µL, 0.1 µL). The volume was adjusted with Sigma H₂O, 4 x RotiLoad was added to a 1 x concentration, and the protein samples were denatured at 95 °C for 5 min. The protein samples were separated via SDS-PAGE in a discontinuous buffer system. The polyacrylamide (PA-) gels were mixed as described in **Table 10** by preparing the separation gel (10 %) first. Following the polymerization, the stacking gel with loading wells was added. The proteins were loaded into the loading wells of the PA-gels and concentrated within the stacking gel by running the system at 70 V in a 1 x Tris / glycine / SDS blotting buffer, and separated in the separation gel at 99 V (see **Table 9** for materials). The system was paused when the smallest band of the protein ladder reached the lowest point of the PA-gel and PA-gels were immediately processed further as described in the next section.

Table 10: Components for the preparation of separation and stacking gels for electrophoresis.

COMPONENTS	SEPARATION GEL	STACKING GEL
ddH ₂ O	4 mL	3.4 mL
Polyacrylamide	3.3 mL	830 µL
1.5 M Tris (pH 8.8)	2.5 mL	–
1.5 M Tris (pH 6.8)	–	630 µL
10 % SDS (pH 7.2)	100 µL	50 µL
Ammonium persulfate (APS) (10 %)	100 µl	50 µL
Tetramethylethylenediamine (TEMED)	5 µL	5 µL

2.5.4 Protein visualization via silver staining

PA-gels were stained via the *Pierce Silver Stain Kit* according to the manufacture's protocol [198]. Essentially, the gels were washed twice with ddH₂O for 5 min, fixed with a 30 % ethanol and 10 % acetic acid solution (in ddH₂O) for 15 min, and washed again with a 10 % ethanol solution (in ddH₂O) and subsequently twice with ddH₂O for 5 min each. Then, the gels were prepared with the sensitizer working solution (1 : 500 sensitizer in ddH₂O), washed twice with ddH₂O for 1 min each and stained with stain working solution (1 : 50 enhancer in stain) for 30 min. The staining was followed by washing twice with ddH₂O for 20 seconds (s) and developed with developer working solution (1 : 50 enhancer in developer) for 3 - 5 mins. The developing was stopped by adding 5 % acetic acid solution (in ddH₂O) for

10 min. PA-gels were photo documented by the ChemiDoc MP imaging system (see **Table 9** for materials).

2.5.5 Liquid chromatography coupled mass spectrometry

For proteome and secretome analysis, CM and cellular fractions of nFB (n = 5) and CAF cultures (SE-CAF = 6, NS-CAF: EC-CAF = 3 and TE-CAF = 3) were prepared as described in **chapter 2.2.5**. Liquid chromatography coupled MS (LC-MS) analysis has been performed by Dr. rer. nat. Gereon Poschmann at the 'Core Facility: Molecular Proteomics Laboratory' of Prof. Dr. rer. nat. Kai Stühler of the HHU-D with the following protocol, which was provided and described in detail earlier by Poschmann et al. and Grube et al., and as similarly described in **chapter 2.5.2** [199,200]:

Briefly, 10 mL of CM was centrifuged (1000 x g, 4 °C, 5 min) and after sterile-filtration (pore size: 0.2 µm Acrodisc MS syringe filter) of the supernatant, proteins precipitated by adding 2.5 mL 50 % (w / v) TCA buffer and SLS to a final concentration of 0.1 % (w / v). Precipitated proteins were pelleted, washed with acetone, briefly dried and resuspend in 50 µL urea buffer (30 mM Tris base, 2 M thiourea, 7 M urea, 4 % (w / v) CHAPS (pH 8.5) in water). After protein concentration determination using the 660 nm assay (Pierce, Thermo Fisher Scientific), 2 µg protein per sample were shorty stacked in a PA-gel, stained with Coomassie brilliant blue, and protein containing bands excised from the gel. Gel bands were de-stained, proteins reduced with dithiothreitol, alkylated with iodoacetamide and after addition washing steps and vacuum-drying digested with trypsin overnight. Resulting peptides were dried in a vacuum concentrator and one third of the sample subjected to LC coupled MS analysis in 0.1 % (v / v) trifluoroacetic acid in water. First, peptides were separated on an *Ultimate 3000 rapid liquid separation system* (RSLC, Thermo Fisher Scientific) as described [201]. Briefly, peptides were trapped on a *trap column* (Acclaim PepMap100 C18, 2 cm length, 3 µm particle size, 100 Å pore size, 75 µm inner diameter, Thermo Fisher Scientific) and separated using a 2 h gradient on a *C18 material* (Acclaim pepMapRSLC, 25 cm length, 2 µm particle size, 100 Å pore size, 75 µm inner diameter, Thermo Fisher Scientific). Second, eluting peptides were injected into a *Fusion Lumos* (Thermo Fisher Scientific) mass spectrometer, operated in positive mode, via a nano source electrospray interface (spray voltage: 1.5 kV). Data was acquired in data-independent mode: After a survey scan in the orbitrap analyzer (resolution: 60'000, scan range 380-985 m / z, maximum injection time 100 ms, automatic gain control target: 400'000, profile mode), precursors were isolated in 2 x 30 slightly overlapping 10 m / z windows in the mass range from 385 - 981 m / z, fragmented by higher-energy collisional dissociation (collision energy 30 %) and analyzed in the orbitrap (resolution: 15'000, scan range 145 - 1450 m / z, maximum injection time 40 ms, automatic

gain control target: 100'000, centroid mode). The loop count was 30. Protein identification and quantification from MS data was carried out with DiaNN 1.8.1 with standard parameters unless stated otherwise. A spectral library was predicted from protein entries from the MaxQuant2.1.0.0 contamination list and 81837 *Homo sapiens* entries downloaded from the UniProt KB proteome section on 12th January 2023. Methionine oxidation was included as variable modification in the search. Only Proteins were considered showing a q-value on PSM and protein group level of < 0.01 and only proteins, which were identified with at least two different peptides included in the analysis.

For the analysis of the proteins in this thesis: all protein classification were included for proteins identified in the cellular fraction (intracellular, signal-peptide, transmembrane, and unconventional protein secreted) whereas proteins classified as 'intracellular' were excluded for secretome analysis.

2.5.6 Enzyme-linked immunosorbent assay

The *Human LGALS3BP Enzyme-linked immunosorbent assay (ELISA) Kit* was used according to the manufacture's protocol [202]. Supernatant from nFB, SE-, EC-, and TE-CAF (each n = 3) were collected after 24 h incubation and immediately proceeded. The supernatant was diluted with the corresponding sample diluent from the kit (1 : 500) and a total of 100 µL of supernatant dilution was added per well and incubated for 2 h at 37 °C. Afterwards, the wells were washed and 100 µL of 1 x detection antibody solution was added for 1 h at 37 °C. Every washing step included the discarding of the supernatant and repeated addition (4 x) of 300 µL 1 x wash buffer per well. After another washing step, 100 µL x streptavidin-HRP solution was added for 40 min at 37 °C followed by a washing step. 100 µL / well of TMB substrate solution was added, incubated for 20 min at RT and protected from light. Immediately, 100 µL / well of stop solution was added, mixed gently and the absorbance was measured at 450 nm and 655 nm (as background control) by the iMark microplate absorbance reader. Each biological replicate was measured as technical duplicate (see **Table 9** for materials).

2.5.7 Immunofluorescence staining

For immunofluorescence staining, cells (2102EP and EC-CAF) were fixed with 3.7 % formaldehyde for 30 min at RT, washed 3 x with PBS, permeabilized with 0.5 % Triton in PBS for 5 min at RT and washed again. Cells were blocked with 1.5 % bovine serum albumin (BSA) in PBS, incubated with first antibody over night at 4 °C and then incubated for 1 h with secondary antibody. DAPI was used as nuclear staining control (see **Table 9** for materials). As experimental control, cells were incubated with the secondary antibody only (**Table 11**).

Table 11: Antibodies used in this study.

ANTIBODY	HOST	DILUTION	CLONE	ORDER NR	COMPANY
NANOG	Mouse monoclonal	1 : 100	1E6C4	SC-293121	Santa-Cruz
OCT3 / 4	Mouse monoclonal	1 : 100	C-10	SC-5279	Santa-Cruz
Goat anti-mouse IgG (H+L) Alexa-Fluor 488	Goat polyclonal	1 : 500	-	A-11029	Thermo Fisher Scientific

2.6 Bioinformatic analysis and high throughput data repository

2.6.1 Online tools and programs

The graphical overview was generated with <https://www.biorender.com> (**Figure S1**) or <https://bioicons.com> and altered by using the program Affinity Designer 2.0. For principal component analysis (PCA), data was analyzed with 'PCAGO' (<https://pcago.bioinf.uni-jena.de>). For the generation of violin and volcano plots, 'pandas', 'seaborn', and 'matplotlib' were applied in 'Python' [203–206]. For heatmap generation with hierarchical clustering, MORPHEUS (<https://software.broadinstitute.org/morpheus/>) was used. Venn diagrams were generated by 'InteractiVenn' (<http://www.interactivenn.net>). The 'DAVID' algorithm (<https://david.ncifcrf.gov>) based on various categories ('KEGG-pathway', 'GOTERM_BP_DIRECT', 'GOTERM_MF_DIRECT') (FDR < 0.05) was used for molecular function predictions of the deregulated genes and illustrated as dot plots with 'ImageGP' (<http://www.ehbio.com/ImageGP/>) [207,208]. Protein-protein-interactions predictions were explored by the 'STRING' algorithm (<https://string-db.org>) [209]. Heatmaps of gene expression for cell infiltration correlations are based on the 'TIMER2.0' database (<http://timer.cistrome.org>) with the algorithms EPIC, MCPOUNTER, xCell, and TIDE [210]. For estimations of cell infiltration, the gene signatures calculated by Aran et al. (xCell) based on various transcriptome data (ENCODE, FANTOM5, and HPCA) were used for analysis [211].

2.6.2 Primer synthesis

If offered, publicly available primer sequences from the *PrimerBank* were used (<https://pga.mgh.harvard.edu/primerbank/index.html>) (amplicon size 50 - 200 bp, primer size ~ 20 bp) [212]. By *in silico* aligning, primers sequences were tested (<http://genome.ucsc.edu>) for being exon spanning, matchless to other sequences of the genome, and covering all isoforms or all protein coding isoforms of the required gene [213]. If not publicly available, new oligonucleotides were designed by determining the gene sequence (<https://grch37.ensembl.org/index.html>) and using *Primer3web* (<https://primer3.ut.ee>) (GC content > 50 %, melting temperature: 60 °C) [214,215]. Newly designed primer pairs were

also *in silico* confirmed. Either way, specificity of oligonucleotides to target sequence / gene were tested initially before using them in this study (melting temperature and melting curve).

2.6.3 Statistical analysis

If not stated otherwise in the materials and method section, statistical significance between analysis groups were determined by applying a two-tailed Student's *t*-test after determining the equality of two variances by means of *F*-test and are indicated by asterisk (* $P < 0.05$, ** $P < 0.01$, *** $P < 0.001$).

2.6.4 Data accessibility

Raw data of the DNA methylation (GSE228405), RNAseq (GSE229047) and LC-MS (PXD049249) generated in this study are publicly available via 'Gene Expression Omnibus' (GEO; <https://www.ncbi.nlm.nih.gov/geo/>) or via PRIDE (<https://www.ebi.ac.uk/pride/>), respectively. All other data of this study are given in the main or supplemental figures and tables, and extended data (e.g., because of > 40'000 data points for statistical analyzed DNA methylation data) are available upon request.

3 Results

3.1 Characterization of GCT-derived CAFs

3.1.1 GCT-derived CAFs' origin and cell type verification

In this study, twelve different CAFs populations were isolated from freshly dissected GCT samples. Overall, six CAF cultures originated from patients diagnosed with SE (age of diagnosis 23 - 40 years), and six from patients with NS (age of diagnosis 23 - 43 years) (**Table 12**). Patients with SE mostly presented the CS I (five out of six), and only one patient was graded as stage II but according to the IGCCCG classification all patients were classified as 'Good prognosis' (**Table 12**). Conversely, the staging of NS-patients was diverse (stage I: two; stage II: two; stage III: two) with mostly good prognosed cases (five out of six) and only one poor prognosed patient (**Table 12**). Three CAF cultures originated from patients with EC, and three with TE (**Table 12**). Hereby, EC-CAF's stemmed from patients with low CS and 'Good Prognosis', and TE-CAF from patients with higher staging and one with 'Poor Prognosis' (**Table 12**). Regarding the tumor's original site, all SE- / EC-CAF's derived from the primary tumor but the majority of TE-CAF were isolated from tumor recurrences (**Table 12**). As control group, nFB were included (patient data not included).

Table 12: Clinical patient information – the tumor origin of the GCT-derived CAF cultures.

Overview of the median age and range of age at diagnosis, the CS (I - III), the IGCCCG classification ('Good', 'Intermediate'; or 'Poor'), the tumor original site (primary or recurrence) divided into the patient's diagnosis (SE or NS with further division into EC and TE). Stated as numerous quantity and percentage distribution. Adapted from [1].

	TOTAL		SE-CAF		NS-CAF		EC-CAF		TE-CAF	
AGE AT DIAGNOSIS (YEARS)	n = 12	(%)	n = 6	(%)	n = 6	(%)	n = 3	(%)	n = 3	(%)
Median	32		33		32		32		32	
Range	23 - 43		23 - 40		23 - 43		23 - 43		28 - 35	
STAGE										
I	7	58	5	83	2	33	2	67	0	0
II	3	25	1	17	2	33	1	33	1	33
III	2	17	0	0	2	33	0	0	2	67
IGCCCG CLASSIFICATION										
Good	11	92	6	100	5	83	3	100	2	67
Intermediate	0	0	0	0	0	0	0	0	0	0
Poor	1	8	0	0	1	17	0	0	1	33
CAF ORIGIN										
CAF from primary tumor	10	83	6	100	4	66	3	100	1	33
CAF from recurrence	2	17	0	0	2	33	0	0	2	67

For the confirmation of the cell cultures' fibroblastic origin and purity, the morphology, gene expression, and protein markers, as well as the i(12p) status, a common chromosomal feature of GCTs, were screened for [50,51].

All different CAF cultures presented a fibroblastic cell structure with long elongated spindle-like cell formations under 2D cultivation conditions (**Figure 5a**). Among the various GCT-CAF subtypes and the nFBs, no noticeable distinction in morphology was observed (**Figure 5a**; **Figure S2**). Immunohistochemical stainings for OCT3 / 4 and NANOG were positive in the

control EC cell line 2102EP, but negative in the CAF cultures (one EC-CAF showed exemplary) (**Figure 5b; Figure S3**). The cultivation of any kind of immune cell was excluded by the fact that all established CAF cultures were solely of adherent nature. Based on the morphology and the negativity for GCT marker on protein level, this was the primary indication of cultivating fibroblastic cells.

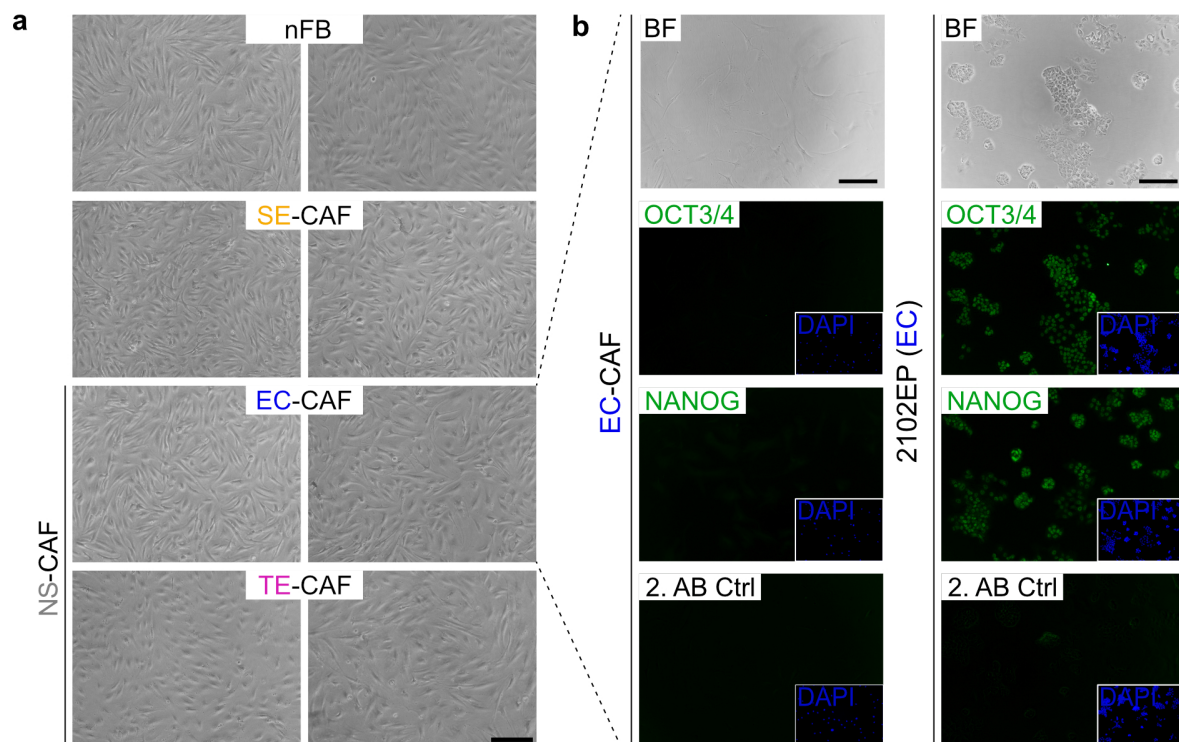


Figure 5: Confirmation of CAF cultures – Morphology and immunofluorescence stainings.

(a) Microscopic observation: exemplary brightfield images of the nFB, SE-, EC-, and TE-CAF's morphology (n = 2 / subtype). Scale bar = 250 μ m (b) Immunofluorescence stainings for OCT3 / 4 and NANOG (both green) exemplary in one EC-CAF and in the GCT cell line 2102EP (EC) as positive control as well as brightfield pictures and secondary antibody (AB) stainings as technical control. DAPI was used as nuclear staining control. Scale bar = 500 μ m. Adapted from [1].

For further verification of purity, the CAF cultures were analyzed for gene expression of various cell markers by qRT-PCR. All CAFs were negative for common GCT entities markers (*PRAME* (SE), *SOX2* (EC), *GATA3* (CC), *FOXA2* (YST)) and showed only low expressions of other cell markers (*PECAM1* (endothelial cells), *HSD17B3* (Leydig cells), *SOX9* (Sertoli cells)) (**Figure 6**). Contrariwise, nFBs and CAFs highly expressed FB markers (*ACTA2*, *FAP*, *S100A4*, *VIM*) in contrast to GCT cell lines (TCam-2, 2102EP, JAR, GCT72) and endothelial cells (HUVEC) whereas the expression levels of the distinct FB markers varied between the GCT-CAF subgroups but also between the individual GCT-CAF populations (**Figure 6**).

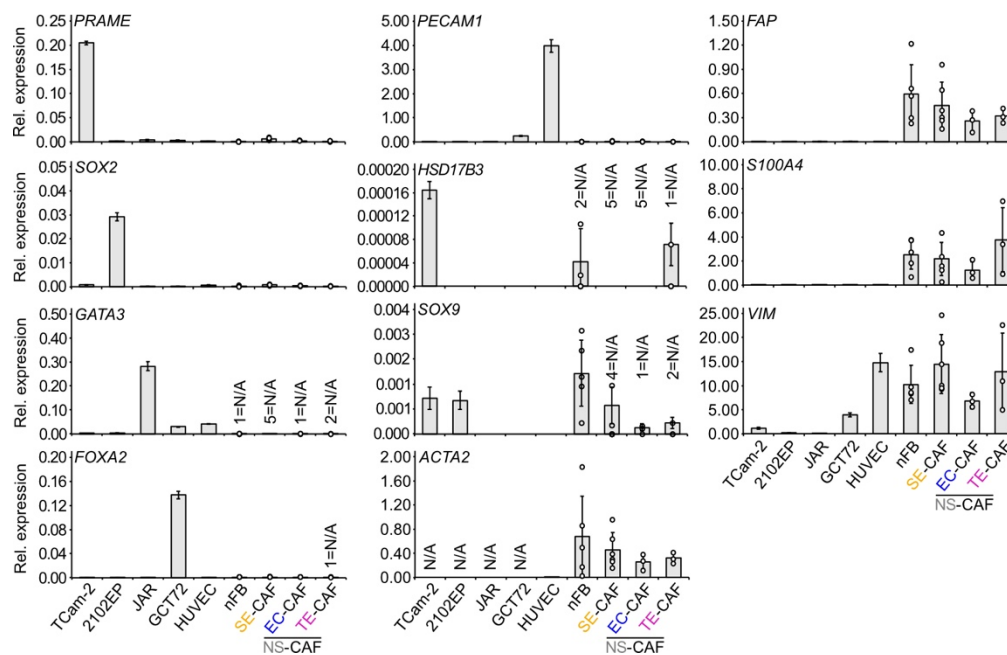


Figure 6: Confirmation of CAF cultures – Gene expression of cell markers.

qRT-PCR analysis: relative gene expression of markers indicative for GCT subtypes (*PRAME* (SE), *SOX2* (EC), *GATA3* (CC), *FOXA2* (YST)), endothelial cells (*PECAM1*), Leydig cells (*HSD17B3*), Sertoli cells (*SOX9*), and FBs (*ACTA2*, *FAP*, *S100A4*, *VIM*) in nFB (n = 5), the distinctive GCT-CAF subtypes (SE-CAF: n = 6; NS-CAF: EC-CAF (n = 3), and TE-CAF (n = 3)), and GCT cell lines (TCam-2 (SE), 2102EP (EC), JAR (CC), GCT72 (YST)) and endothelial cells (HUVEC) as positive control. The housekeeper genes *ACTB* and *GAPDH* were used for data normalization. Standard deviation: for single biological replicates calculated from technical triplicates (TCam-2, 2102EP, JAR, GCT72, and HUVEC), otherwise calculated from biological replicates (nFB and GCT-CAF). Adapted from [1].

To prevent inadvertent culturing of GCT cells, the isochromosome i(12p) status was examined by using the qRT-PCR strategy developed by Fichtner et al. [51]. The positive and negative controls of the aforementioned study were included into this panel. The mean plus the standard deviation (SD) of the relative expression of analyzed non-GCT patient tumor samples (negative control) was usually used as cutoff (= 1.46) (**Figure 7**). All nFB, SE-, and NS-CAF were negative for the chromosomal aberration, i(12p), except one outlier within the EC-CAF subgroup (**Figure 7**). However, given the combination of approaches by morphology, gene expression and protein markers, and isochromosome status one can conclude the fibroblastic origin and purity of the isolated GCT-CAF cultures.

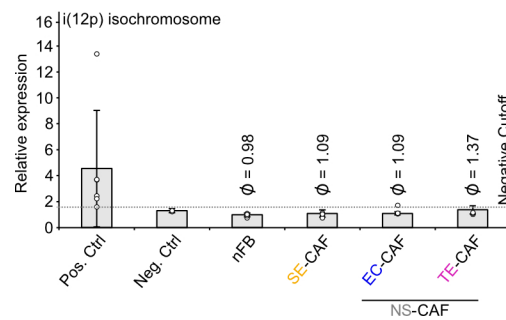


Figure 7: Confirmation of CAF cultures – Chromosomal aberration.

qRT-PCR analysis of the isochromosome status i(12p) in nFB (n = 5), the GCT-CAF subtypes (SE-CAF: n = 6; NS-CAF: EC-CAF (n = 3), and TE-CAF (n = 3)), and positive (n = 6) and negative (n = 2) controls from GCT and non-GCT patient tumor samples provided by Fichtner et al. [51]. Means and SD calculated from biological replicates. Dashed line: negative cutoff calculated from the mean plus the SD of the relative expression of the negative controls (= 1.46). Adapted from [1].

3.1.2 DNA methylome of GCT-derived CAFs

As first step of the GCT-CAF characterization, the DNA methylome of the distinct GCT-CAF and nFB cultures were analyzed. For this purpose, the purity of DNA was confirmed beforehand (**Figure S4**). Considering the overall DNA methylation (5mC) landscape, nFB, SE- and NS-CAFs clustered differentially in a PCA (**Figure 8a**). All GCT-CAFs grouped apart from nFBs whereas the NS-derived CAF subgroups (EC- and TE-CAF) also clustered separately from each other (**Figure 8a**). The overall DNA methylation status of EC-CAFs seemed to be more similar to SE-CAFs than TE-CAFs while intragroup differences of the 5mC levels were the lowest between EC-CAFs and the highest between TE-CAFs (**Figure 8a**).

B-values equal to 1 (or = 100 %) represent the strongest DNA (hyper-) methylation and B-values equal to 0 (or = 0 %) no DNA (hypo-) methylation [216]. When calculating the overall 5mC level average within the GCT-CAF subtypes, nFB and TE-CAF had lower 5mC contents than SE- and EC-CAFs (54.2 % and 56.8 %) with equally low averaged DNA methylation (both 46.6 %) (**Figure 8b**).

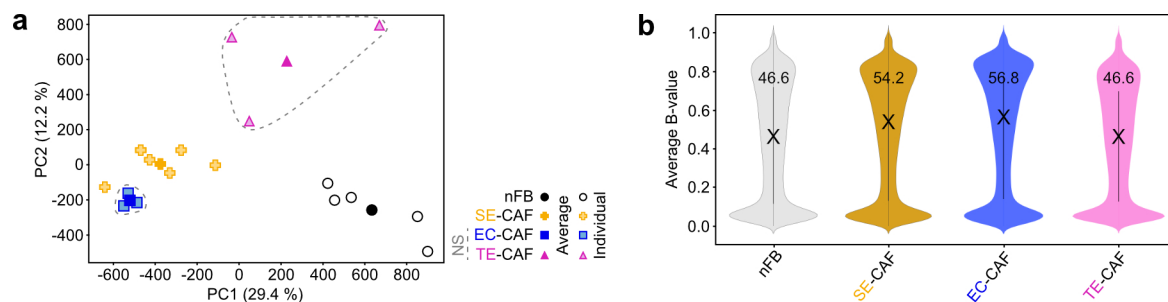


Figure 8: Overall DNA methylation status of GCT-derived CAFs.

(a) PCA of overall DNA methylation level of nFB and the GCT-CAF subgroups. Illustrated as single biological replicates (light color) and their average (dark color). Dashed line: NS-CAF. (b) Violin plots of the 5mC levels of the various nFB and GCT-CAF subgroups. White 'X' indicates the average of averaged DNA methylation content. For a & b: nFB (n = 5), SE-CAF (n = 6), NS-CAF (EC-CAF (n = 3), and TE-CAF (n = 3)). Adapted from [1].

Further, one-by-one comparison of the CpG dinucleotides of the separate GCT-CAF subtypes to the nFBs revealed hypo- (green, negative values) and hypermethylated (red, positive values) CpG dinucleotides (**Table S2**). The highest number of differentially methylated dinucleotides was detected in SE-CAF (38 hypometh., 42 hypermeth.) and EC-CAF (38 hypometh., 43 hypermeth.) with a fold change (FC) of $> 8 / < -8$ and $P < 0.05$ (**Figure 9a**). In contrast, TE-CAF had only 15 differentially methylated dinucleotides (9 hypometh., 6 hypermeth.) compared to nFB, which reflects the priorly observed similarity of the global DNA methylation levels in nFB and TE-CAF (**Figure 9a**).

The analyzed CpG dinucleotides are assigned to a certain location and functional section in the genome. The categories used are regions 1500 bp or 200 bp upstream the transcriptions start site ('TSS1500' and 'TSS200') within the promoter, the 5' and 3' untranslated regions ('5'UTR' and '3'UTR'), the first exon ('1st exon') and 'gene body'. Regions with a high number of cytosines followed by a guanine, referred to as CpG islands, are most frequently observed in the promoter [155]. The local assignment in the context of CpG islands is further outlined to describe the regions in close proximity: 'N shelf', 'N shore', 'CpG island', 'S shore', and 'S shelf' (**Figure 9b**) [217]. CpG dinucleotides with no defined designation are categorized as 'open sea'.

In the context of these local assignments, the vast majority of hyper- and hypomethylation (61 - 69 %) occurred in the 'gene body' independently of the GCT-CAF subgroup (**Figure 9c**). Followed by altered DNA methylation patterns allocated in the 'TSS1500' (9 - 15 %) and the '5'UTR' (12 - 13 %) (**Figure 9c**). Regarding the CpG island context, most of the differentially methylated dinucleotides were found in 'open sea' (62 - 68 %) followed by 'CpG island' (7 - 16 %) and 'N shore' (9 - 10 %) (**Figure 9c**).

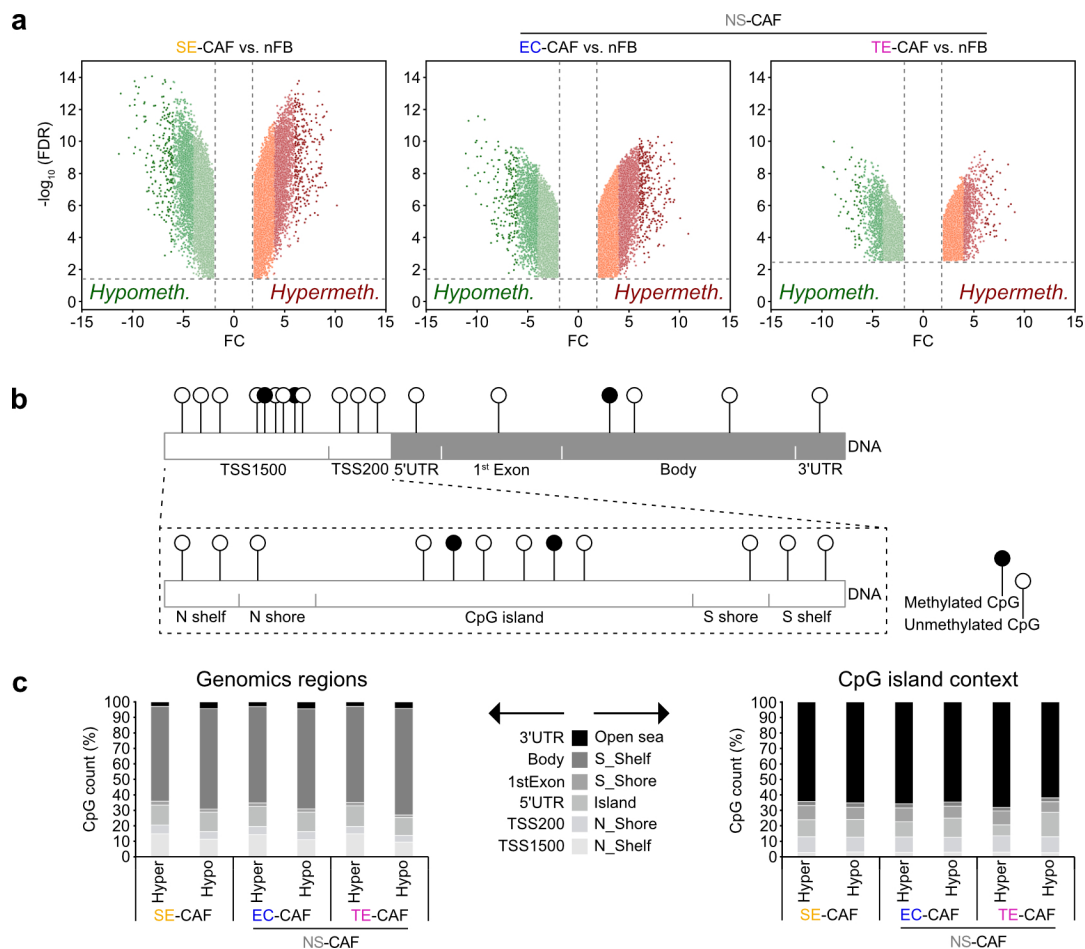


Figure 9: Hypo- and hypermethylated CpG dinucleotides of GCT-derived CAFs.

(a) Volcano plots of differentially methylated CpG dinucleotides in the distinct GCT-CAF (SE-CAF: $n = 6$; NS-CAF: EC-CAF ($n = 3$), and TE-CAF ($n = 3$)) in comparison to nFB ($n = 5$) ($\text{FC} > 2 / < -2$, $\text{FDR} < 0.05$). (b) Illustration of the localization in the genome context describing the regions: TSS1500, TSS200, 5'UTR, 1st exon, (gene) body, and 3'UTR, and localization in the CpG island context with the regions: N shelf, N shore, CpG island, S shore, and S shelf. Unmethylated and methylated CpGs illustrated in white and black. Adapted from the Illumina data sheet [216]. (c) Proportional distribution of differentially methylated CpG counts within one GCT-CAF subtype and one methylation status across the genomic region. TSS: transcription start site; UTR: untranslated region. For a & c: nFB ($n = 5$), SE-CAF ($n = 6$), NS-CAF (EC-CAF ($n = 3$), and TE-CAF ($n = 3$)). Adapted from [1].

Overall, the DNA methylation status revealed similarities between SE- and EC-CAF, and the most differences within these two GCT-CAF subgroups when compared to the control nFB. In contrast, nFB and TE-CAF showed higher similarities based on the overall DNA methylation content.

3.1.3 Transcriptome of GCT-derived CAFs

As second step of the GCT-CAF characterization, the transcriptome was analyzed by RNAseq. RNA quality was checked before RNAseq analysis (Figure S5).

By unsupervised hierarchical clustering, SE- and EC-CAFs demonstrated comparable differential expressed genes (DEGs) (indicated by blue (low expression) and red (high

expression)) whereas TE-CAF deviated with a more unique expression pattern than SE- and EC-CAF (**Figure 10a; Table S3**)

When comparing the transcriptome of GCT-CAF to nFB, SE- and EC-CAF presented the most differential expressed genes (DEGs) (downregulated: 1202 and 1075; upregulated: 1340 and 1192, $\log_{2}FC > 2 / < -2$; $FDR < 0.05$) (**Figure 10b**). The number of DEGs in TE-CAF was moderately lower with 364 downregulated and 975 upregulated genes ($\log_{2}FC > 2 / < -2$; $FDR < 0.05$) (**Figure 10b**).

By Venn diagrams, commonly down- (258) and upregulated (473) DEGs in GCT-CAFs were shown compared to nFBs, respectively (**Figure 10c**). Furthermore, SE- and EC-CAF shared a high number of DEGs (622 and 522 down- and upregulated) in comparison to only a few shared DEGs with TE-CAF (12 and 14 downregulated, and 68 and 39 upregulated) (**Figure 10c**). Besides these common DEGs, SE-, EC-, and TE-CAF demonstrated also exclusive DEGs (downregulated: 310, 181, and 80; upregulated: 277, 158, and 395) (**Figure 10c**).

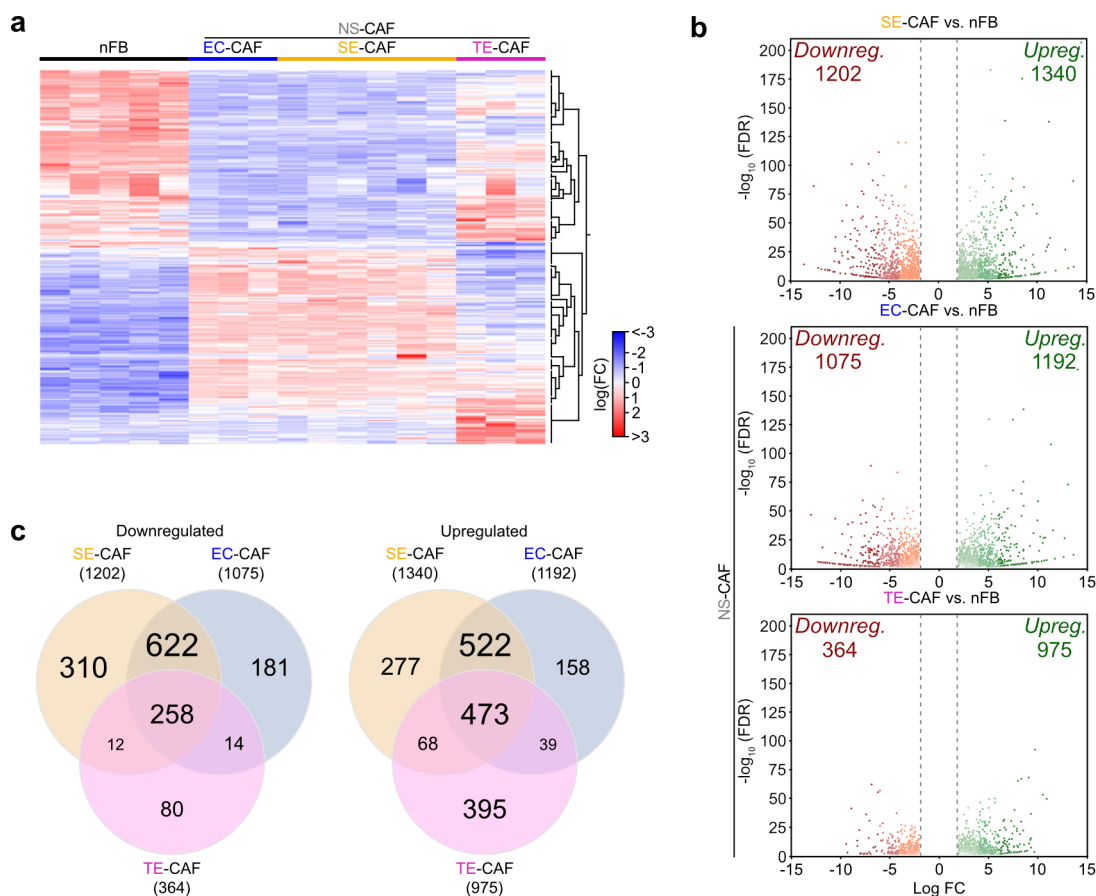


Figure 10: Overall gene expression patterns and DEGs of GCT-derived CAFs.

RNAseq data ($\log_2FC > 2 / < -2$, $FDR < 0.05$) represented as **(a)** heatmap hierarchical clustered for DEG and GCT-CAF subtypes, as **(b)** volcano plots of down- (red) and upregulated (green) genes, and as **(c)** Venn diagrams of commonly and exclusively down- and upregulated genes in the GCT-CAF subtypes. For **a - c**: nFB (n = 5), SE-CAF (n = 6), NS-CAF (EC-CAF (n = 3), and TE-CAF (n = 3)). Adapted from [1].

To understand the biological relevance behind the DEGs, they were evaluated by functional annotation (DAVID) analysis.

Upregulated genes in SE-, EC-, and TE-CAF in comparison to nFB were commonly annotated with the structural remodeling of tissues as genes were involved in e.g., 'cell(-cell) adhesion', 'ECM organization', 'metallocarboxypeptidase / metalloendo-peptidase inhibitor activity', 'integrin binding', and 'ECM-receptor interaction' (**Figure 11**, orange). Further, collective upregulation of genes related to the immune response was observed ('complement and coagulation cascades', 'staphylococcus aureus infection', 'complement activation', and 'inflammatory response') (**Figure 11**, khaki).

The involvement of upregulated genes in signaling pathways and several processes summarized as 'Activity' was peculiar for SE-CAFs (**Figure 11**, dark blue). Here, SE-CAFs showed increased PI3K and BMP signaling as well as increased signal transduction via cytokines ('cytokine-cytokine receptor interaction' and 'cytokine receptor activity') (**Figure 11**, dark blue). Further, genes were upregulated annotated with 'growth factor / calcium channel / sodium channel activity', and involved in controlling second messenger levels ('3'.5'-cyclic-nucleotide phosphodiesterase activity', and '3'.5'-cyclic-GMP phosphodiesterase activity') (**Figure 11**, light blue). Downregulated genes of SE- and particularly EC-CAF suggested a reduced cell division rate and cell proliferation (e.g., 'chromosome segregation', 'mitotic spindle organization', and 'G2 / M transition of mitotic cell cycle') (**Figure S6**, yellow).

In contrast, gene annotation analysis of upregulated genes in TE-CAF revealed a high number of uniquely, and to a lesser extent commonly expressed genes (**Figure 11**). In addition to the PI3K-Akt signaling pathway as seen in SE-CAFs, also MAPK and cGMP-mediated signaling-based genes were higher expressed compared to nFB (**Figure 11**, dark blue). Most prominently, TE-CAF showed elevated gene expression of genes involved in development of the heart, lung alveolus, ureteric bud and teeth ('odontogenesis') as well as 'epithelial cell differentiation', and 'cardiac muscle cell proliferation' (**Figure 11**, purple). This might reflect the involvement of TE-CAF in the development and differentiation of TE cells into all three germ layers. Vice versa, SE- and EC-CAFs showed a reduced expression of genes related to differentiation and developmental processes (e.g., 'anterior / posterior pattern specification', 'thymus development', 'regulation of neuron differentiation', and 'cochlea morphogenesis') (**Figure S6**, purple).

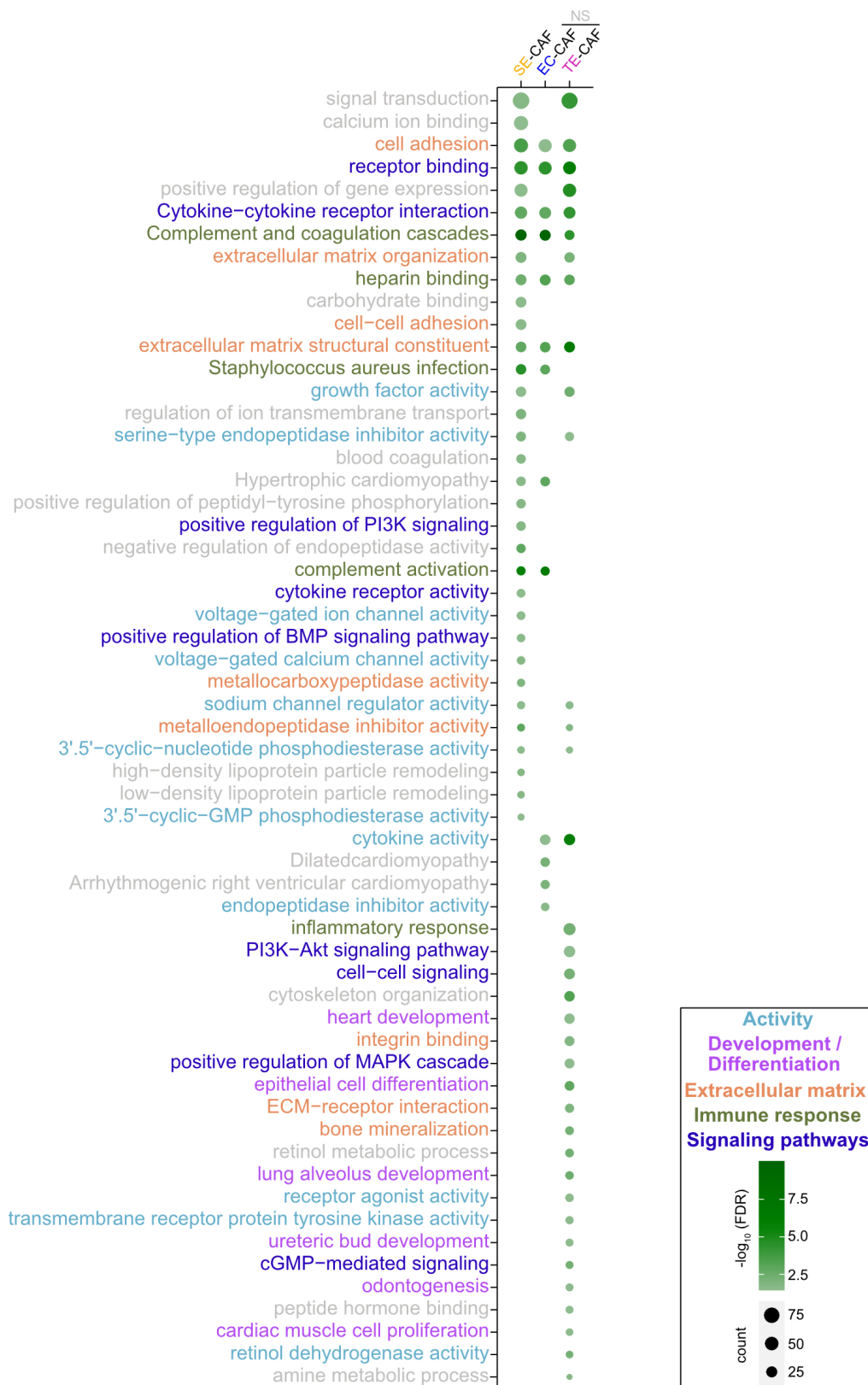


Figure 11: Annotation analysis of upregulated genes.

Gene annotation analysis via david.ncicrf.gov of upregulated genes ($\log_{2}FC > 2$, $FDR < 0.05$) in SE-CAF ($n = 6$) and NS-CAF (EC-CAF ($n = 3$), and TE-CAF ($n = 3$)) compared to nFB ($n = 5$). Annotations summarized as groups: receptor / channel / protein regulatory activity (bright blue), developmental / differentiation processes (purple), ECM (orange), immune response (khaki), and involved signal pathways (dark blue). Shade of green indicating P ($-\log_{10}(\text{FDR})$) and circle size reflecting the number of genes involved in the annotation. Annotations included when counts > 5 and $FDR < 0.05$ of DAVID analysis calculations. Adapted from [1].

3.1.4 Proteome and secretome of GCT-derived CAFs

As third and final step of the GCT-CAF characterization, the proteome and secretome were investigated by LC-MS analysis.

Quality of prepared samples was confirmed by silver staining of SDS gels (**Figure S7**). The most differentially translated (804, 164, and 65) and secreted (108, 45, and 23) proteins were observed in SE-CAFs, followed by EC-CAFs and then TE-CAFs compared to nFBs (**Figure 12a, b; Table S4; Table S5**). A total of 50 and 12 proteins were commonly produced and secreted in all three GCT-CAF subgroups, respectively (**Figure 12a, b**). Furthermore, SE- and EC-CAFs shared 110 translated and 32 secreted additional proteins (**Figure 12a, b**). Similar to the previous **chapters 3.1.2** and **3.1.3** (DNA methylome and transcriptome analysis) again high similarities between TE-CAF and nFB were observed.

Next, to understand the biological importance of the identified proteins, they were explored by protein-protein prediction analysis showing their involvement in biological processes and their molecular function (physical and functional interaction). These STRING analyses, revealed a high number of proteins of the cellular fraction were involved in e.g., 'carbohydrate metabolic process', 'generation of precursor metabolites and energy', 'lipid metabolic process', and 'small molecule biosynthetic / metabolic process' summarized as metabolic processes (**Figure 12c**, green). This might indicate an overall higher metabolic activity of GCT-CAF than nFBs.

Furthermore, elevated proteins of the proteome and the secretome, were annotated in the connection with the ECM (proteome: 'cell adhesion'; and secretome: e.g., 'ECM binding' and 'metallocarboxypeptidase activity'), immune response (proteome: e.g., 'immune effectors process'; and secretome: '(acute) inflammatory response') and peptidase activity (proteome: 'exopeptidase activity'; and secretome: '(exo)peptidase activity') (**Figure 12c, d**, orange, khaki, and light blue).

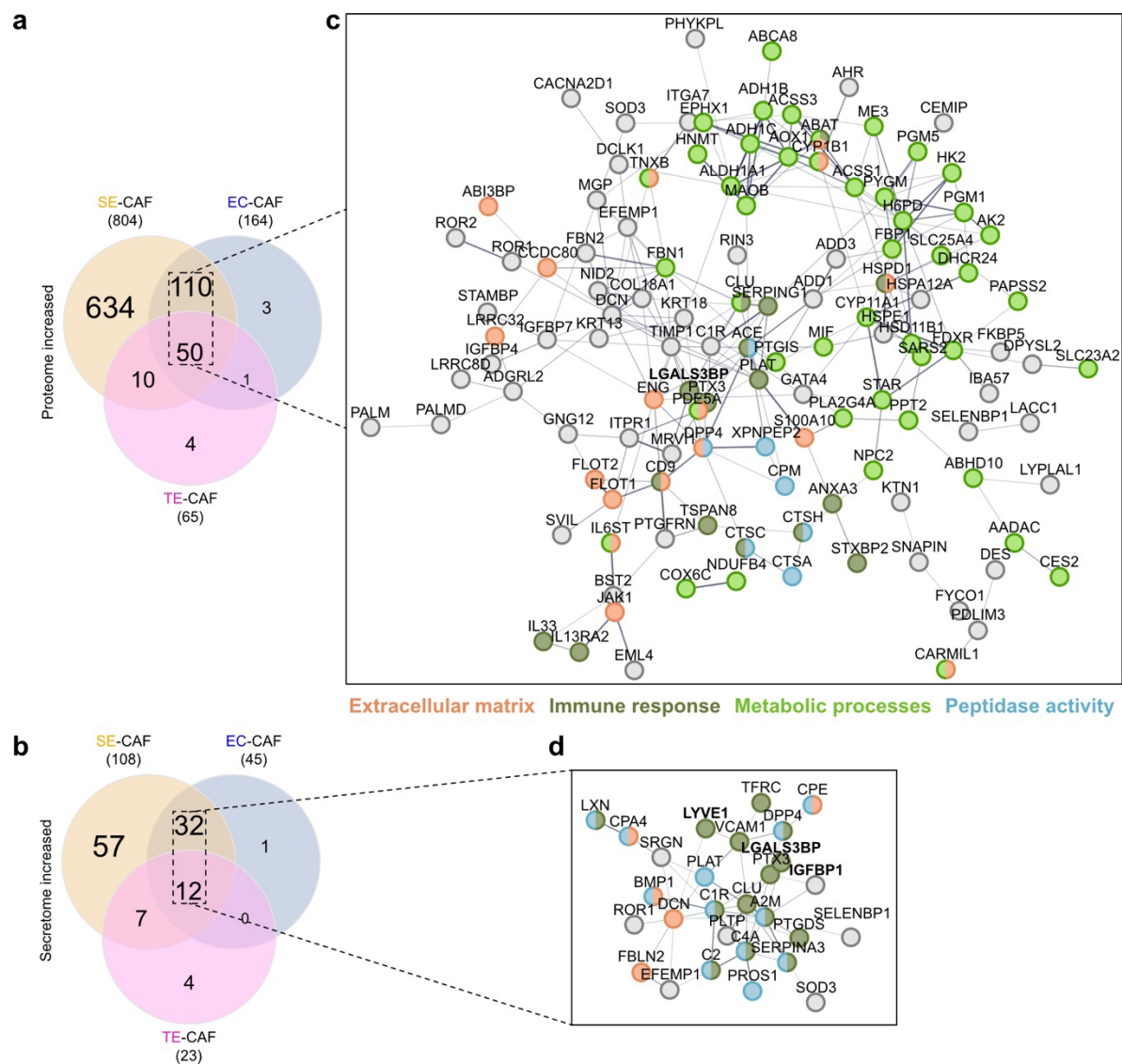


Figure 12: Interaction prediction and annotation analysis of the proteome and secretome of GCT-derived CAFs.

Illustration of commonly and exclusively produced / translated (**a**) and secreted (**b**) proteins of SE-CAF ($n = 6$) and NS-CAF (EC-CAF ($n = 3$), and TE-CAF ($n = 3$)) compared to nFB ($n = 5$). (**c**, **d**) Physical and functional protein interaction prediction via string-db.org of commonly produced and secreted proteins. Color coding of the proteins involved as following ECM (orange), immune response (khaki), metabolic processes (green), peptidase activity (light blue). Student's t -test and FDR corrected. Adapted from [1].

3.1.5 Correlation of high throughput data for target identification

As first step of the high throughput data correlation, DNA methylome and transcriptome data were aligned. Secondly, these identified factors were compared to proteins of the secretome data to identify interesting targets for further analysis on their influence on proliferation and cisplatin sensitivity-related factors.

For this, only CpG dinucleotides were considered, which 1.) were annotated to a gene, 2.) had at least 3 CpG dinucleotides queried by the 850k array, and 3.) more than 50 % of the

total CpGs were differentially methylated ($FC > 2 / < -2$, $FDR < 0.05$) in a genomic region or in a CpG island compared to nFBs (**Figure 13a**).

These differentially methylated genes (DMGs) were then aligned with DEGs ($\log FC > 2 / < -2$, $FDR < 0.05$). Thereby, 46, 36, and 11 hypomethylated / upregulated (green), and 76, 75, and 17 hypermethylated / downregulated (red) factors were identified in SE-, EC-, and TE-CAF compared to nFB, respectively (**Figure 13b**, **Table S6**). When further compared to secreted factors (**Figure 12b**), the *Galectin 3 Binding Protein* (*LGALS3BP* / *LGALS3BP*) and the *Lymphatic Vessel Endothelial Hyaluronan Receptor 1* (*LYVE1* / *LYVE1*) emerged in the SE- and EC-CAF subgroups (**Figure 13b, c** in bold). Based on the former LC-MS analysis, high secretion levels of the *Insulin Like Growth Factor Binding Protein 1* (*IGFBP1*) in SE-, EC-, TE-CAF compared to nFB (difference = 6.1, = 6.3, and = 4.6) had been noticed and *IGFBP1* was additionally incorporated in this study (**Figure 12b**, **Table S5**).

The factors, *LGALS3BP* / *LGALS3BP*, and *LYVE1* / *LYVE1* were found to be hypomethylated (SE-CAF: $FC = -3.5$ and $= -3.2$; EC-CAF: $FC = -3.5$ and $= -3.0$), upregulated (SE-CAF: $\log FC = 2.4$, and $= 11.0$; EC-CAF: $\log FC = 2.4$, and $= 10.8$), and secreted (SE-CAF: difference = 1.9 and $= 4.3$; EC-CAF: difference = 3.2 and $= 4.5$) in SE- and EC-CAF (**Figure 13b, d, e**). Gene expression levels were validated by qRT-PCR, verifying significantly upregulated *LGALS3BP* and *LYVE1* expression. An ELISA confirmed secretion of *LGALS3BP* in the supernatants of SE- and EC-CAF (**Figure 13f** and **g**).

For SE- and EC-CAFs, *IGFBP1* / *IGFBP1* was also upregulated ($\log FC = 7.9$ and $= 8.1$) and highly secreted (difference = 6.1 and $= 6.3$), and showed a tendency of high expression when validated by qRT-PCR (**Figure 13d, e, f**).

When illustrating TE-CAF individually, increased gene expression of *IGFBP1* and *LYVE1* ($\log FC = 5.7$ and $= 3.3$) and elevated secretion of *IGFBP1* (difference = 4.6) was noticed, which could not be proven by qRT-PCR (**Figure 13d** and **f**). Surprisingly, secreted *LGALS3BP* levels were also significantly increased in TE-CAFs, even though this factor was not recognized in the LC-MS analysis prior (**Figure 13e** and **g**).

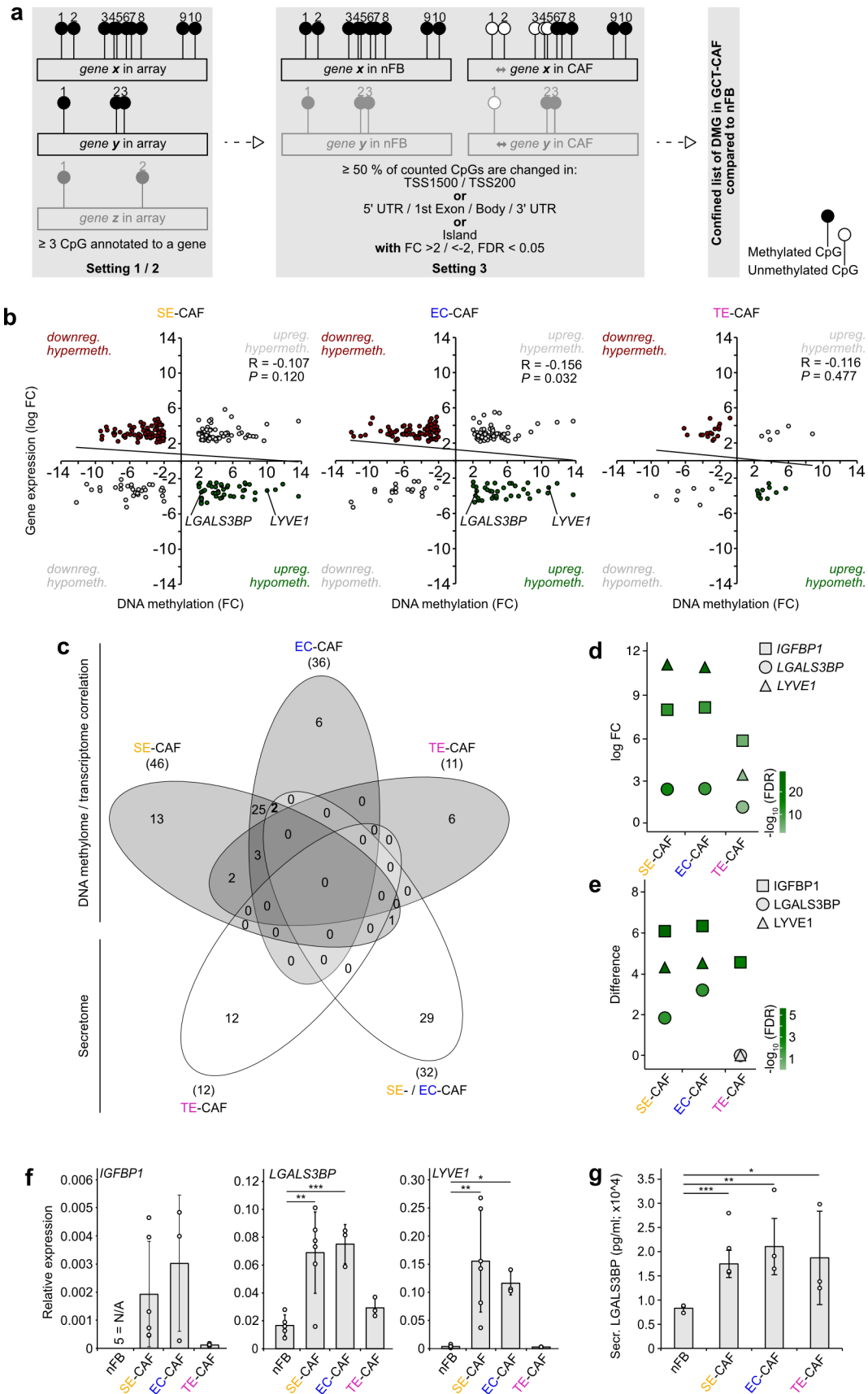


Figure 13: Correlation and validation of high throughput data.

(a) Exemplary illustration of filter settings for a confined gene list of DMGs, which fulfill all of the following: Setting 1: CpGs annotated to a gene (here 'gene x, y, and z'), Setting 2: only genes with at least 3 CpGs or more (here 'gene x and y'), Setting 3: when 50 % of the CpGs of the associated gene (here 'gene x') are differentially methylated in a genomic region ('TSS1500' / 'TSS200', '5' UTR' / '1st Exon' / 'Body' / '3' UTR', or 'island') in the GCT-CAF subgroups compared nFBs (FC: > 2 / < -2 , FDR < 0.05). (b) Correlation of DMGs and DEGs. (c) Comparison between DNA methylome / transcriptome correlation and secretome data. (d) RNAseq data, (e) LC-MS data of secreted proteins, and (f) validation by qRT-PCR of the identified factors *IGFBP1* / IGFBP1, *LGALS3BP* / LGALS3BP, and *LYVE1* / LYVE1. (g) Validation of LGALS3BP secretion by ELISA. SD for a - f: nFB (n = 5), SE-CAF (n = 6), NS-CAF (EC-CAF (n = 3), and TE-CAF (n = 3)). SD for g: each n = 3. * < 0.05 , ** < 0.01 , *** < 0.001 (t-test). Adapted from [1].

3.2 Functional and prediction analysis of identified factors on GCT cell lines

3.2.1 IGFBP1, LGALS3BP, and LYVE1 treatment effects on GCT cell lines

Following the characterization of GCT-CAFs and identification of novel factors in the TME of GCT, the effect of IGFBP1, LGALS3BP, and LYVE1 treatment on GCT cell lines was investigated. In a previous study of our working group, Skowron et al. showed the protective effect of nFB CM pretreatment of GCT cell lines by reducing cisplatin sensitivity [116]. Therefore, at first instance, the influence of the identified factors on the proliferation rate of GCT cell lines were tested.

In EC cell lines, IGFBP1, LGALS3BP or LYVE1 treatment reduced the proliferation rate after 8 - 10 d in comparison to untreated control EC cells (**Figure 14a**). Hereby, the reduction of proliferation was time and cell line dependent. In response to LGALS3BP, 2102EP presented as the most sensitive cell line. For NCCIT and NT2/D1, the daily treatment led to a weaker reduction in proliferation compared to untreated. For the SE cell line TCam-2, IGFBP1, LGALS3BP or LYVE1 application was rather ineffective in reducing the proliferation rate (**Figure 14a**).

Moreover, the previous treatment of GCT cell lines with nFB CM led to reduced cisplatin sensitivity and altered gene expression of known cisplatin sensitivity-related factors [116,117]. After a 10 d treatment with IGFBP1, LGALS3BP or LYVE1, the expression of several cisplatin sensitivity-related factors was induced (**Figure 14b**). For TCam-2 LGALS3BP had the strongest effect on gene expression e.g., induction of several pre-, on-, post-, and off-target genes. Contrary to this, the effects of LYVE1 and IGFBP1 on gene expression in TCam-2 were only moderate (threshold > 1.5 FC). In the EC cell lines, recombinant proteins IGFBP1 or LYVE1 predominantly induced the expression of post- and off-target genes (*BCL2*, *BCLXL*, *TP53*, and *ERBB2*). Upon LGALS3BP treatment, the gene expression patterns were EC cell line dependent whereby 2102EP showed a decreased expression of the cisplatin sensitivity-related factors (**Figure 14b**).

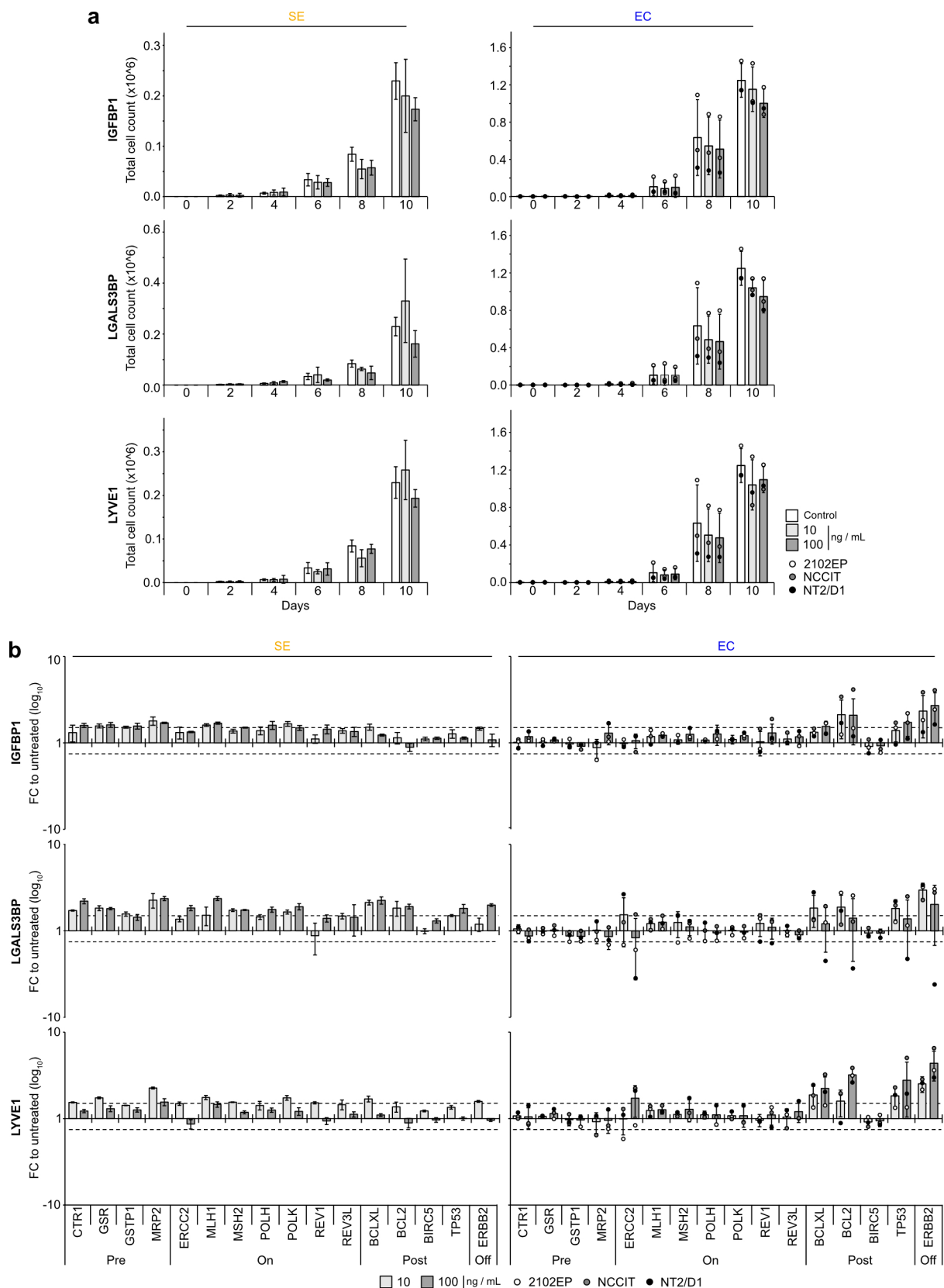


Figure 14: Treatment of GCT cell lines with IGFBP1, LGALS3BP or LYVE1.

SE (TCam-2) and EC (2102EP, NCCIT, NT2/D1) cell lines treated with IGFBP1, LGALS3BP or LYVE1 (10 and 100 ng / mL) daily over 10 d and counted every second day as proliferation assay (a) and harvested after 10 d for qRT-PCR analyses testing for cisplatin sensitivity-related factors (b). Dashed lines indicating the threshold (FC > 1.5). For both: SD of SE is based on technical replicates and of EC is based on biological replicates. Adapted from [1].

3.2.2 Expression of *IGFBP1*, *LGALS3BP*, and *LYVE1* as potential CAF infiltration predictor

As last step, the potential to use the gene expression of the identified target as prediction of CAF infiltration in GCTs was explored.

Therefore, the gene expression status of *IGFBP1*, *LGALS3BP* or *LYVE1* were correlated to the level of CAF infiltration in TCGA tumor samples including the (T)GCT cohort by TIMER2.0. High Spearman correlation values indicated a positive correlation between *LGALS3BP* and *LYVE1* expression and CAF infiltration in different tumor entities. Hereby, *LYVE1* appeared to be predictive for CAF infiltration in several tumor entities. However, *LGALS3BP* and *LYVE1* expression correlated the strongest with CAF infiltration, inter alia in (T)GCT tumors (**Figure 15a**, dark red). The correlation between *IGFBP1* expression and CAF infiltration was found to be only weak (**Figure 15a**, light red). By using the expression of *IGFBP1*, *LGALS3BP*, and *LYVE1*, a moderate to weak purity of the GCT cell populations was demonstrated ($Rho = 0.2$; $= -0.021$; $= 0.313$), suggesting non-tumoral subpopulations (**Figure 15b**, Purity). *LGALS3BP* or *LYVE1* expression correlated positively but *IGFBP1* expression correlated less strong with CAF infiltration ($Rho = 0.643$; $= 0.596$; $= 0.202$) (**Figure 15b**, xCell). Thus, high expression of *LGALS3BP* and *LYVE1* can be associated with a CAF subpopulation predominantly in the GCT cohort proposing their expression as potential prediction tool in GCT research.

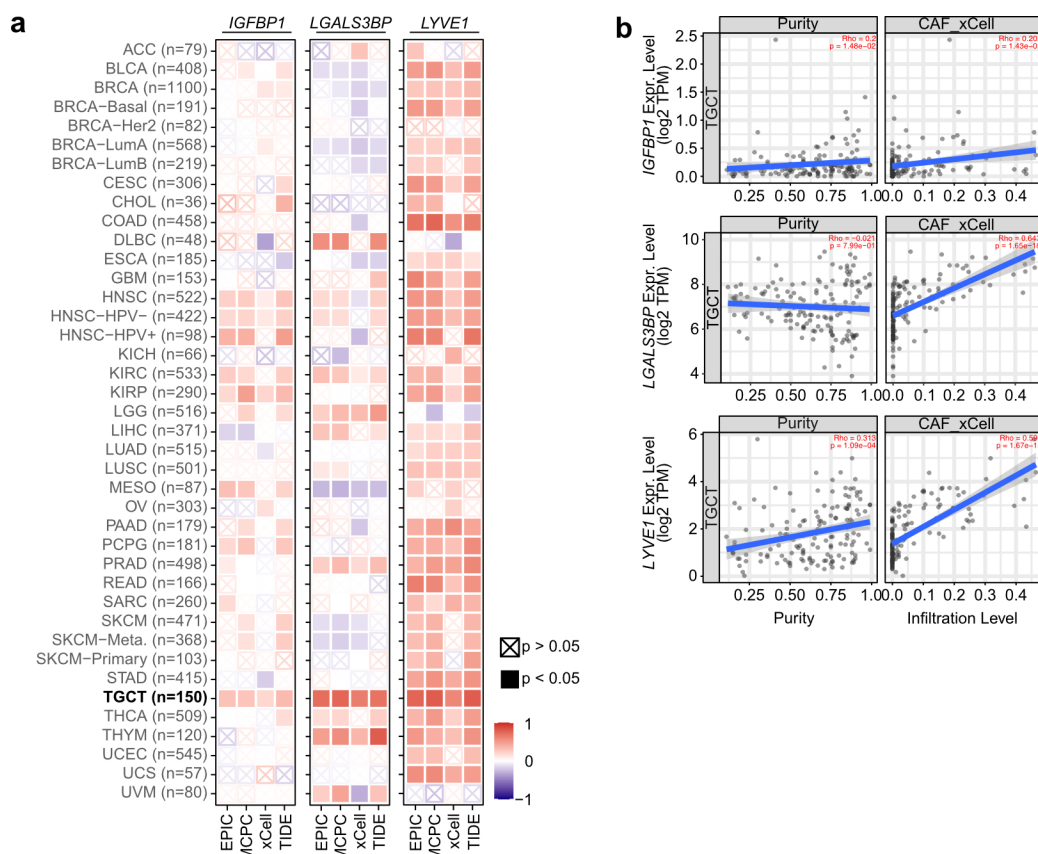


Figure 15: *IGFBP1*, *LGALS3BP*, and *LYVE1* expression as prediction tool.

(a) Partial Spearman correlation estimated CAF infiltration in 40 different cancer types (TCGA cohorts) based on *IGFBP1*, *LGALS3BP* or *LYVE1* expression via TIMER2.0 (used algorithms: EPIC, MCPCounter (MCPC), xCell, TIDE). Red: significant positive correlation, blue: significant negative correlation. (b) Estimated purity of the TCGA GCT cohort based on *IGFBP1*, *LGALS3BP* or *LYVE1* expression as well as the correlation of the infiltration level of CAF based on the gene signatures defined by the xCell algorithm. Adapted from [1].

4 Discussion

This study comprehensively characterized GCT-derived CAF cultures *ex vivo* by analyzing the DNA methylome, transcriptome and proteome. In total, 12 CAF cultures originating from SE, EC and TE tumors revealed the superior potential of SE and EC of pushing CAF into a greater activation state than TE. The high throughput analyses were of huge value in highlighting the novel factors IGFBP1, LGALS3BP, and LYVE1 in the TME of GCTs. The identified effector molecules influenced the proliferation and gene expression of cisplatin sensitivity-related factors in GCT cells lines suggesting a reciprocal interaction between CAF and GCT cells. Thereby, GCTs influence the CAF's activation state while CAF affect the tumor growth and cisplatin response. The novel targets IGFBP1, LGALS3BP, and LYVE1 potentially serve as future prognostic or diagnostic markers and as foundation for potential therapeutical interference with CAF in the GCT framework.

4.1 Characterization of GCT-derived CAFs

4.1.1 Establishment

The most important foundation of research is a reliable and realistic study cohort. Hence, as basis of this study, CAF cultures were thoroughly collected and established from individual GCT patients representing a reliable study cohort.

Firstly, in regard to classification, most of the prepared CAF cultures originated from SE tumors and the smaller proportion originated from EC and TE. The collection was solely dependent on the scheduled operations at the *Department of Urology* of the *University Hospital Düsseldorf*. Therefore, the distribution of tumor subtypes from which the CAF cultures were freshly prepared reflected the realistic occurrence of GCTs. This led to a distribution of 50 % to 25 % and 25 % of SE, EC, and TE approximating the calculations of the *Robert-Koch-Institut* for Germany from 2019 / 2020 with 62 % for SE, 8 % for EC, and 17 % for TE [7].

Further, the tumors of origin from which SE- and EC-CAFs derived were mainly good prognosed and lower clinical staged whereas TE-CAFs stemmed from patients with higher staging and even one with 'Poor Prognosis'. Generally, most SE tumors are classified as 'Good Prognosis' (90 %) and generally none are poor prognosed according to the IGCCCG classification [62,68]. Regarding the common prognosis distribution of NS tumors (good: 56 %, intermediate: 28 %, and poor: 16 %), this is rather reflected by the TE-CAF group with 67 % being good and 33 % being poor prognosed and not by the EC-CAF group (good: 100 %) [62,68]. Higher staging and poorer prognosing of the here presented TE-CAF original tumors can potentially be associated with the fact that two out of three TE-CAFs came from tumor recurrences.

A different age peak for SE (35 years of age) and NS (25 years of age) as described by Stang et al., was not observed as in this study the median age for patients with SE was 33 years and with EC or TE 32 years [8]. However, the GCT-CAFs of this study presented a reliable cohort as they reflect the tumor diagnosis distribution of the most common GCT type II subtypes with the most frequent prognosis and staging classifications of primarily young patients.

Secondly, the general limitation of this study regarding the used control group (nFB) is worth mentioning. As stated earlier, intra- and inter-organ / tumor heterogeneity leads to several distinct nFB and CAF subtypes within the body and even within one organ / tumor [122,137,138]. However, using non-testicular nFB was the only feasible way due to difficulties in availability of testicular nFB. In 2021, only approximately 2600 gender-affirming surgeries were conducted in Germany according to the *Statistisches Bundesamt* (based on the operation and procedure code) [218]. The only statistics available by the *Statistisches Bundesamt* included both male-to-female and female-to-male transitions whereby one individual can be listed multiply as several surgeries per patient are necessary. Thus, access to potentially healthy testicular nFBs is rather limited.

Another alternative would have been normal tissue adjacent to the tumor (NAT) which is generally used as control in cancer research. But comprehensive gene expression analyses of non-tumoral-associated healthy tissue, NAT and tumor samples in eight different entities revealed that NAT represented a rather intermediate state between healthy and tumor tissue. The alignment of healthy tissue to tumor tissue revealed additional DEGs compared to the NAT to tumor alignment suggesting the potential loss of information [219]. Appropriately, Croft et al. showed the difference between pancreatic ductal adenocarcinoma-derived CAF populations in relation to their spatial localization. While the tumor proximal CAFs' expression patterns (*PDPN*⁺, *HIF1A*⁺, *PDL1*⁺, *VEGFA*⁺) resembled myCAFs and these expression patterns were associated with a poorer clinical outcome, distal CAFs were still classified as iCAF based on their immune activating expression profiles (e.g., *C3*⁺, *CCL5*⁺, *CXCL9*⁺) [220]. In conclusion, due to the limited access to non-testicular nFBs, the potential concealing of important DEGs by using NAT, and by avoiding the influence of tumor cells on distant FBs, healthy but non-testicular nFBs of the crista iliaca were used in this study.

Thirdly and lastly, as foundation for further analyses, the fibroblastic origin of the established GCT-CAF cultures was reliably determined on transcriptional (*ACTA2*⁺, *FAP*⁺, *S100A4*⁺, *VIM*⁺; *PRAME*⁻, *SOX2*⁻, *GATA3*⁻, *FOXA2*⁻, *PECAM1*⁻, *HSD17B3*⁻, *SOX9*⁻), translational (NANOG⁻, OCT3/4⁻) and morphological level. As mentioned before, CAF / FB markers are tissue- and tumor-specific and mostly combinedly used though in the context of testes, the descriptions of FBs are rare. Sohni et al. analyzed healthy human neonatal and adult testes for cell subset classifications on a single cell level. They defined FBs with only one marker

(*S100A4* / *FSP1*) [221]. Other single cell analyses during the perinatal development of testes described stromal cells, but not FBs individually, by stating *VIM* (and other markers) as differentially expressed in comparison to all testicular cells [109].

Further, fibrotic retroperitoneal tissue residuals of GCT patients after chemotherapy had chromosomal anomalies of chromosome 12 in one third of the patients [174]. The authors postulated that the fibrotic retroperitoneal tissue residuals might emerged from the tumor cell their selves explaining the i(12p) gain. Therefore, the CAF cultures here were extensively proven to be of fibroblastic nature, a reflection of GCT type II subtypes, and with a solid control group making them a persuasive model to study CAF in the GCTs.

4.1.2 DNA methylome, transcriptome and proteome profiling

For the further comprehensive characterization of GCT-CAFs, three molecular levels were portrayed: the DNA methylome, transcriptome, and proteome.

Examination of the DNA methylome revealed that cancer association of FBs is also measurable on DNA methylation level as GCT-CAFs showed a distinct DNA methylation landscape compared to nFBs. Even further, the DNA methylation of GCT-CAF subtypes differed among each other. Coherently, Clavreul et al. compared glioblastoma-derived stromal cells with non-tumoral brain tissue-derived stromal cells and identified two glioblastoma-stromal cell subsets based on their DNA methylation profiles [222]. Hence, analysis of the DNA methylome might be suitable to find further subsets within one CAF subtype. However, for this a higher number of individual CAF cultures per subset is needed.

The difference in DNA methylation leading to two cell subsets found by Clavreul et al. was also reflected on cellular level as only one cell subset was tumor-promoting [222]. As discussed further below, the GCT-CAF subtypes specific variations were also discovered on transcriptome and proteome level with indications of different associated cell activation states. CpG methylation levels can be modified exogenously by drugs e.g., all-trans retinoic acid (ATRA). The *in vitro* application of ATRA changed the DNA methylation content in leukemia cell lines and was utilized as anti-fibrotic agent in pancreatic stellate cells, the progenitors of pancreatic ductal adenocarcinoma CAFs by e.g., reducing pancreatic stellate activation and enhancing anti-tumoral behavior [223,224]. Hence, targeting the DNA methylation in GCT-CAFs might be suitable for reversing their activation state.

Using the methylation status of one certain gene region has found its way into the diagnostic and prognostic medicine. As previously shown, the *SHOX2* methylation status, a gene which was found to be differentially methylated in this thesis as well, can be used as biomarker in a wide range of malignancies e.g., lung cancer, colonic adenomas and colorectal

adenocarcinomas, and even malignant pleural effusions [225–227]. However, the diagnostic or prognostic value of any of the DMGs, as listed in **Table S6**, need further elaboration.

For transcriptional profiling, only bulk transcriptome-wide analyses were performed in this study. Therefore, identification of distinct subpopulations within one patient-derived CAF culture, as seen in single cell analysis, is not achievable. However, based on gene expression profiles, these GCT-CAF cultures were categorized into existing CAF classes (see **chapter 1.2.2**). Therefore, gene sets of 22 known CAF classes from different tumor entities were compared to upregulated genes in SE-, EC-, and TE-CAF (**Figure S8**) [138,228–234]. Most of the GCT-CAFs' upregulated genes aligned with the expression patterns of the subtypes iCAF and CAF2. The iCAF class has been described as either proinflammatory or immunosuppressive dependent on their marker profiles and characteristics [147,148]. Along with the upregulated genes being annotated to signaling pathways of the complement system and the inflammatory response, this suggested a proinflammatory GCT-CAF phenotype. In search of alternative treatments for incurable advanced metastatic GCTs, clinical trials for immunotherapeutic approaches were only moderately successful raising the question of potential involvement of said inflammatory CAFs in the therapy resistance [235]. This might be a good starting point for further investigation into whether the inflammatory properties of GCT-CAF are reversible.

The bulk transcriptome-wide analyses also limited the identification of the GCT-CAFs' cell of origin. But, GCT cells as source of the CAF cultures were already excluded, as stated in **chapter 4.1.1**, leaving several cell types, such as resident or recruited FB, epithelial or endothelial cells, pericytes, adipocytes or mesenchymal stem cells as potential cell of origin [236]. Nevertheless, in SE- and EC-CAFs increased expression levels (*AMHR2*, *CLU*, *GATA4*, *KRT18*, *NR5A1*, *PTGDS*, and *WT1*) as well as elevated secretion (*CLU*, *PTGDS*) of common Sertoli cell markers compared to nFB were observed (**Table S3** and **S5**). *In vitro* approaches showed the potential of FB transformation into Sertoli cell-like cells by *GATA4* and *NR5A1* (and *DMRT1*, *SOX9*, and *WT1*) overexpression [237,238]. This raised the question if the GCT-CAF cultures were also reprogrammed into a Sertoli cell-like state. In human, immature proliferative Sertoli cells are found prepubertally whereas matured non-proliferative Sertoli cells prevail after puberty. Further, mature Sertoli cells in adults lose the ability to proliferate due to differentiation [101,239]. Contrariwise, the here described CAF cultures remained proliferative, exceeding more than 20 passages. Furthermore, under physiological conditions, there is no interaction between Sertoli cell or gonocytes and FB. As such, Sertoli cells and spermatogonia are located inside the seminiferous tubules and are demarcated by the basal lamina, while FB reside in the interstitium and the tunica albuginea of the testis [103,240]. This protects the spermatogonia from external effects (blood-testis-barrier) making them solely dependent on signals from Sertoli cells. Vice versa, germ cells

are discussed as partially responsible for the maturation process of SC [101]. As the tumor expands, it disrupts the testicular anatomy and destructs the protective microenvironment for gonocytes sustained by Sertoli cells. This might lead to new cell interactions like FB-GCT interactions but also interchanges between FB and non-tumoral spermatogonia, spermatocytes, spermatids and spermatozoa. The disruption of the seminiferous tubules during tumor progression led to new interactions between nFB / CAF and the intra-tubular microenvironment (Sertoli cells and germ cells), potentially inducing the expression of some Sertoli cell marker genes indicating a (partial) reprogramming to Sertoli cell-like cells [101,103,240]. However, further studies are needed to elucidate this process.

Altogether, the global correlation of these analyses did not only reveal differences between the CAF classes dependent on their tumor subtype origin but also high similarities between TE-CAFs and nFBs. Hereby, especially SE- and EC-derived CAF presented noteworthy changes in comparison to nFBs (+ 7.6 / +8.2 % in 5mC; + 1340 / + 1192 upreg. genes; - 1202 / - 1075 downreg. genes; + 804 / + 164 translated proteins; + 108 / + 45 secreted proteins). Further, the associated signal pathways of the DEGs, and differentially translated and secreted proteins indicated a different (and stronger) activation of SE- and EC-CAF than TE-CAF and nFB.

As observed in other studies, the spatial location or marker positivity can be responsible for the activation state of CAFs and distinct subtypes [220,241]. For colorectal, skin squamous cell, breast, pancreatic, and lung cancer, single cell analyses revealed the universally prevailing GJB2⁺ CAF subclass. This subclass was assigned to a more active state than GJB2⁻ CAFs also defined by elevated expression of protein secretion-, angiogenesis-, and ECM-related genes [241]. Here, rather the prevailing GCT TME in which the CAFs have resided determined the activation state of GCT-CAFs. For this, it is essential to look more into the cell interactions in the testis and the development of GCTs. Generally, it is theorized that GCNIS giving rise to GCT cells being the attempt to undergo the default spermatogenesis program [110]. Also, as the somatic compartment is dependent on signals of the germ cells e.g., for the maturation process of Sertoli cells, absent, or impaired germ cells can negatively influence these processes [101]. Hence, it is no surprise that GCT cells in general also have an activating effect on other stromal cells like FBs as shown in this thesis. Even further, the impact of the tumor cells on the CAF's activation state was shown in a GCT subtype dependent manner. This might be explained by the fact that latent pluripotent SE with the ability to be reprogrammed into an EC-like cell fate and naïve pluripotent EC have a higher potential to activate and sculpture CAFs whereas terminally differentiated TE's influence is less strong. However, with the postulation that TE activate CAF to a lesser extent, it cannot be excluded that CAFs are tumor specific and tumor beneficial modified since annotated pathways of TE-CAFs' upregulated genes were associated with

development and differentiation of all three germ layers. In summary, this showed the importance of the GCT subtype on CAF activation whereby further study should rather focus on CAFs derived from SE and EC.

Subsequently, this raised the question, which specific factors secreted by GCT cells were responsible for the activations process of nFBs to CAFs. For this, re-analysis of previous published secretome data of SE, EC, (and YST, and CC) cell lines led to the identification of seven commonly secreted factors [116]. Single or combination treatment of a nFB culture with the identified factors (recombinant DSG2, GNS, and / or PLOD3) increased the expression of known CAF markers (*ACTA2*, *CXCL12*, *FAP*, *IL6*, *IL8*, *PDGFRA*, *PDPN*) but also of novel GCT specific CAF marker genes (e.g., *LGALS3BP*) (**Figure S9**) [116]. This creates a valuable groundwork for subsequent studies on these factors and their involvement in the activation process of GCT-CAFs.

As a last step of the characterization, the correlation and validation of high throughput data and thorough literature research helped with identification of novel mediators in the TME of GCTs. The hypomethylated, upregulated, and highly secreted *LGALS3BP* / *LGALS3BP* and *LYVE1* / *LYVE1* in and of SE- and EC-CAFs in comparison to nFB were selected as interesting candidates. Because *LGALS3BP* has been previously discussed as a biomarker for lung cancer and as prognostic marker for melanoma, ovarian and gastric cancer [242–245]. Interestingly, *LGALS3BP* has been shown to be a promising target for ADCs in glioblastoma, adenoid cystic carcinoma, squamous cell carcinoma, and neuroblastoma [246–249]. *LYVE1* is highly expressed in colorectal cancer, gastric cancer, and neuroblastoma [250–252]. Moreover, *LYVE1* has been described as a marker for lymph vessels but has also been identified in other cells like macrophages, endothelial and tumor cells [253–255]. Nevertheless, the goal was to include an additional protein to eventually identify a target secreted by all three CAF subtypes. Thus, considering highly differentially secreted proteins from all CAFs compared to nFBs led to the identification of *IGFBP1*. This factor has been already described as a diagnostic and prognostic serum marker in gastro-intestinal and colorectal cancer [256,257]. Concluding, these factors were reasonably selected for a more intensive investigation in this study.

4.2 Functionality of GCT-CAF identified factors on GCT cell lines

4.2.1 Proliferation

Previous work showed the protective effect of nFB CM treatment (HVHF2) on the cell viability of SE, EC and even CC and YST cell lines when additionally treated with cisplatin posing the question, which secreted proteins in the CM are responsible for this effect [116]. Against expectations, the treatment with the newly identified factors in this study like the

recombinant LGALS3BP, and to a lesser extent IGFBP1, rather reduced the proliferation rate of SE and EC cell lines [116]. A study showed that LGALS3BP in the cerebrospinal fluid of patients with cerebral cavernous malformations was remarkably responsible for promoting the proliferation of human induced pluripotent stem cell (hiPSC-) differentiated astrocytes [258]. However, others found that overexpression of *LGALS3BP* in hiPSC-cerebral organoids led to a drastically reduction of β -catenin suggesting the loss of anchoring and explaining their mislocalization within the organoid [259]. Suitably, colorectal cancer cells showed lower growth and migration rate when treated with CM of *LGALS3BP* overexpressing cancer cells [260]. Thus, the contradiction of reduced proliferation in SE and EC cell lines upon LGALS3BP treatment might be associated with a migrative or non-adhesive cell response and lays a good foundation for future studies.

4.2.2 Resistance factors

Next, the effect of IGFBP1, LGALS3BP, and LYVE1 on the cisplatin response pathways of GCTs were examined. An induced expression of the Galluzzi et al. defined cisplatin resistance factors in the SE cell line (pre-, on-, post-, and off-target factors) and in EC cell lines (post- and off-target factors) was observed. Especially LGALS3BP treatment led to the strongest induction. Though in the GCT related context, knockdown of *LGALS3BP* in resistant CC cell lines reversed the resistance towards methotrexate [261]. Generally, LGALS3BP induced expression of *TP53*, *BCL2* and *BCLXL* (post-target factors) and *ERBB2* (HER2) (off-target factor) in SE and EC cells, so molecules involved in mediating the DNA repair response (*TP53*), apoptosis (*TP53*, *BCL2*, *BCLXL*) and pro-survival signals via PI3K and MAPK signaling (*ERBB2*) [262–271]. Cisplatin as a cytostatic compound forms intra-strand DNA adducts, leads to single-strand DNA breaks, inhibition of DNA synthesis, and finally to apoptosis [272]. With the rather globally effects of cisplatin, the numerous resistance mechanisms are expected but seemingly dependent on the cell's developmental origin (endo-/ meso-/ ectoderm or originating from PGCs) [273]. Based on literature, Skowron et al. summarized the so far known resistance mechanisms in GCTs into on- and post-target effects [273]. Together with this data, CAF might be responsible for additional mechanisms of action in GCT's cisplatin resistance (pre- and off-targets) opening a new approach in this research field.

4.2.3 Pluripotency

Using FBs as feeder layers or their CM to maintain pluripotency of undifferentiated human embryonic stem cells (hESCs) are established models in research [274]. This led to the question if FBs / CAFs maintain this capacity in the tumor as well. Previous studies

demonstrated that the GCT's plasticity is dependent on the TME since the SE cell line TCam-2 was reprogrammed *in vitro* by treatment with nFB (+FGF4) and reprogrammed by microenvironmental cues *in vivo* into an EC-like cell fate after xenotransplantation into nude mice [112,114,115]. Furthermore, Wang et al. showed the induction of SOX2 and NANOG expression in gastric cancer cells when treated with gastric cancer-derived CAF CM [275]. Colorectal-related CAF CM treatment also supported cancer cell stemness of colorectal cancer cell lines *in vitro* by upregulation of the stemness markers ALDH and LGR5 [276]. Taken together, this suggests the CAFs' potential to influence cell plasticity. Contrary to expectations, in this study the treatment of TCam-2 (SE) with SE-CAF CM over 10 d had marginal effects on the expression of pluripotency factors in comparison to nFB CM treatment (**Figure S10a**). Yet, daily treatment over 10 d with the identified effector molecules IGFBP1, LGALS3BP, and LYVE1 led to an overall induction of several pluripotency associated factors *GAL*, *GDF3*, *NANOG*, *POU5F1 / OCT3 / 4*, (**Figure S10b**). Especially high concentrations of LGALS3BP led to an approximately 5-fold upregulation of SOX2, a marker demarcating naïve pluripotent (EC) cells (SOX2⁺, SOX17⁻) from latent pluripotent (SE) cells (SOX2⁻, SOX17⁺) [18,60,96]. Regarding the role of LGALS3BP, research found opposing results – besides being a cancer biomarker, Kyrousi et al. showed LGALS3BP to be also important in the nervous system as it is found in human neural progenitor cells (NPC). They showed that *in vitro* and *in vivo* overexpression of *LGALS3BP* impaired the apical to basal NPC specification. In contrast to this thesis, the overexpression of *LGALS3BP* reduced the number of SOX2⁺ NPCs in the ventricular zone, which usually harbors neural stem cells and increased their occurrence basally suggesting premature neural differentiation [259]. In accordance with the data shown here, Zhang et al. observed an increase of *POU5F1 / OCT3 / 4* and SOX2 expression in human periodontal ligament stem cells, representing mesenchymal stem cell like cells, after 21 d addition of recombinant LGALS3BP suggesting a differentiation into osteoblasts, an important cell type for bone tissue development [277]. For IGFBP1 being the second most effective treatment out of the three used recombinant proteins in changing pluripotency marker expression in TCam-2, a previous study showed that at least the co-expression of SOX2 and *IGFBP1* (and other markers) as a reliable prognostic tool for lung adenocarcinoma patients [278]. Also, IGFBP1 secretion by endometrial stromal cells seems to be crucial during the implantation of the trophoblast into the maternal decidua of the uterus [279]. Therefore, the influence of IGFBP1 treatment on TCam-2 is worth further investigation as SE are postulated to have the capacity to differentiate into extra-embryonic tumors (trophoblastic differentiation) [280–282]. Altogether, the data of this thesis indicated an involvement of the identified effector molecules LGALS3BP, and to a lesser degree IGFBP1, in the plasticity of the SE cell line TCam-2 by regulating the gene expression of pluripotency factors.

4.3 Conclusion

Altogether, this study comprehensively characterized GCT-CAF showing the greater potential of SE and EC tumors to activate / differentiate nFB to CAF in contrast to TE. But, independently of the tumor origin, GCT-CAFs can most likely be assigned to the known iCAF and CAF2 subclasses by showing immune response related gene upregulation and protein secretion. High throughput analyses brought forth the novel mediators, IGFBP1, LGALS3BP, and LYVE1, which potentially play an important role in the GCT TME since these factors reduced cancer cell proliferation and induced the expression of cisplatin-sensitivity factors. Thereby, especially LGALS3BP is potentially involved in the GCT plasticity and can be used for monitoring the CAF population under therapy (**Figure 16**).

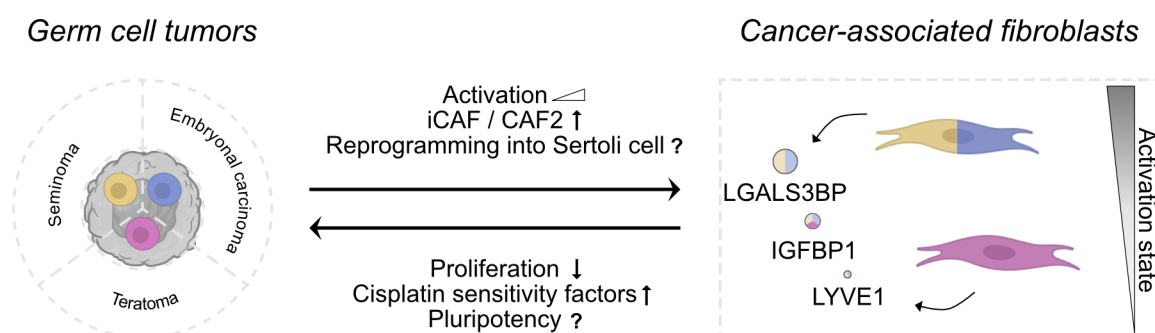


Figure 16: Graphical summary of the results and hypotheses of this study.

The reciprocal interaction between GCT (cell lines) (SE / EC / TE) and associated CAFs whereas the GCT subtype influenced the activation state of CAFs, their CAF subclass affiliation, and potentially reprogramming ability into Sertoli cell-like cell. Hereby, SE- and EC-CAF showed high similarities on DNA methylome, transcriptome, and proteome. Vice versa, the identified hypomethylated, upregulated, and secreted factors IGFBP1, LGALS3BP, and LYVE1 reduced proliferation, induced Cisplatin sensitivity-related gene expression, and potentially play a role in GCT plasticity. Size of 'protein' reflects declining impact according to this study, and color indicates CAF origin. Question marks indicate newly formed hypotheses for future studies.

4.4 Outlook

These results set the groundwork for future studies in the field of the TME, particularly CAFs, in GCTs. For the first time, GCT-CAFs were characterized and novel interesting candidates (IGFBP1, LGALS3BP, and LYVE1) in the communication cascade of CAFs and GCT cells were discovered.

Altered gene expression in GCT cell lines affected by CAF-derived soluble mediators strongly indicated CAFs' involvement in cisplatin resistance. As shown in many other cancers, CAF play a crucial part in drug resistances. It is of utmost importance to further elucidate these mechanisms. For this, the newly acknowledged affected resistance mechanisms (post- and off targets) should be focused on.

Investigations into the reversion, dedifferentiation, or deactivation of the greatly activated SE- and EC-CAF should follow this study. Also, interference with the inflammatory state of GCT-CAF offers potential. However, LGALS3BP emerged as the most potent candidate for future studies as its treatment showed the strongest effects in reducing the proliferative capacity, inducing cisplatin sensitivity-related gene expression, impacting GCT plasticity, and predicting CAF infiltration. Together with the already existing approaches to target LGALS3BP (e.g., with ADCs) or to use as diagnostic / prognostic marker in general, future GCT research should explore this strategy further. This way, LGALS3BP can be potentially useful in a dual treatment of GCTs together with standard treatment to slow-down tumor progress or in serving as prognostic or diagnostic marker.

CAF as crucial perpetrator in cancer should not be neglected. Therefore, further analyses of CAFs should also be expanded to the additional GCT type II subtypes like YST and CC as they reflect the rarest subtypes and most difficult ones in respect to prognosis and treatment.

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List of abbreviations

A

Å	Ångström
AB	Antibody
ACTA2	Actin alpha 2, smooth muscle (gene symbol)
ACTB	Actin beta (gene symbol)
ADC	Antibody-drug conjugate
AFP	α -fetoprotein (gene / protein symbol)
AJCC	American Joint Committee on Cancer
AKT	AKT serine /threonine kinase (gene / protein symbol)
APC	Antibody-photo absorber conjugates
APS	Ammonium persulfate
apCAF	Antigen presenting cancer-associated fibroblast
ASDR	Age standardized death rate
ASR	Age standardized rate
ATCC	American Type Culture Collection
ATRA	All-trans retinoic acid
AWMF	Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften e.V.

B

BEP	Bleomycin + etoposide + cisplatin treatment
BLIMP1	B lymphocyte-induced maturation protein 1 (gene symbol)
bp	Base pair
BSA	Bovine serum albumin

C

CAF	Cancer-associated fibroblast
CAR	Chimeric antigen receptor

List of abbreviations

cCAF	Cycling cancer-associated fibroblast
CC	Choriocarcinoma
CCDC68	Coiled-Coil domain containing 68 (gene / protein symbol)
cDNA	Complementary deoxyribonucleic acid
CD10	Membrane metalloendopeptidase (protein symbol)
CD29	Fibronectin receptor subunit beta (protein symbol)
CD105	Endoglin (protein symbol)
CD146	Melanoma cell adhesion molecule (protein symbol)
cGMP	Cycling guanosin monophosphate (protein symbol)
CHAPS	3-((3-Cholamidopropyl) dimethylammonio)-1-propanesulfonat
CIS	Carcinoma <i>in situ</i>
Cisplatin	Cis-diaminodichloroplatinum
cm	Centimeter
cm ²	Square centimeters
cm ³	Cubic centimeters
CM	Conditioned medium
CNS	Central nervous system
Co-cells	Compartmentalizing cells
COL1A2	Collagen type I alpha 2 (gene / protein symbol)
CS	Clinical stage
Ct	Cycle threshold
CT	Computer tomography
CXCL	C-X-C motif chemokine ligand (gene / protein symbol)
CXCR	C-X-C motif chemokine receptor (gene / protein symbol)

D

d	Day
DAPI	4',6-diamidino-2-phenylindole

List of abbreviations

DAVID	Database for Annotation, Visualization, and Integrated Discovery
dCAF	Developmental cancer-associated fibroblast
ddH ₂ O	Double-distilled water
DDR	Discoidin domain receptors
DDT	Dichlorodiphenyltrichloroethane
DEG	Differentially expressed gene
DKG	Deutsche Krebsgesellschaft e.V.
DMEM	Dulbecco's Modified Eagles Medium
DMG	Differentially methylated gene
DMSO	Dimethyl sulfoxide
DNA	Deoxyribonucleic acid
DNMT	DNA methyltransferase (gene / protein symbol)
dNTP	Deoxynucleotide triphosphate
Downreg.	Downregulated / Downregulation
DSG2	Desmoglein 2 (protein symbol)
E	
EAU	European Association of Urology
EC	Embryonal carcinoma
ECM	Extracellular matrix
EC-HHU-D	Ethic committee of the Medical Faculty of the Heinrich Heine University Düsseldorf
EDARADD	Ectodysplasin-A receptor associated adapter protein (gene / protein symbol)
EDTA	Ethylenediaminetetraacetic acid
e.g.	Exempli gratia / for example
ELISA	Enzyme-linked immunosorbent assay
EP	Etoposide + cisplatin treatment
ERK1/2	Extracellular signal related kinase 1 / 2 (protein symbol)

F

FAP	Fibroblast activation protein (gene / protein symbol)
FAK	Focal adhesion kinase (protein symbol)
FB	Fibroblast
FBS	Fetal bovine serum
FC	Fold change
FDA	US Food and Drug Administration
FDR	False discovery rate
FOXA2	Forkhead Box A2 (gene / protein symbol)
FSP1	Fibroblast specific protein 1 (protein symbol)

G

g	Gram
GAPDH	Glyceraldehyde-3-Phosphate Dehydrogenase (gene symbol)
GCNIS	Germ cell neoplasia <i>in situ</i>
GCT	Germ cell tumor
GNS	(recombinant protein)
GPR77	G-protein coupled receptor 77 (protein symbol)
GO	Gene ontology analysis
GWAS	Genome wide association studies
Gy	Gray

H

h	hour
β-hCG	Human chorionic gonadotropin
HCl	Hydrochloric acid,
HDAC	Histone deacetylase (gene / protein symbol)
HDI	Human development index
HHU-D	Heinrich Heine University Düsseldorf

List of abbreviations

hESCs	Human embryonic stem cells
hiPSC	Human induced pluripotent stem cell
Hypermeth.	Hypermethylated / Hypermethylation
Hypometh.	Hypomethylated / Hypomethylation

I

i(12p)	Isochromosome 12 p-arm
iCAF	Inflammatory cancer-associated fibroblast
IGCCCG	International Germ Cell Cancer Collaborative Group
IGCNU	Intratubular germ cell neoplasia unspecified
IGF	Insulin like growth factor (gene / protein symbol)
IGFBP1	Insulin like growth factor binding protein 1 (gene / protein symbol)
IL6	Interleukin 6 (gene / protein symbol)
IL8	Interleukin 8 (gene / protein symbol)

K

KIT	Receptor tyrosine kinase
kb	Kilobase
kV	Kilovolt

L

LC	Liquid chromatography
LC-MS	Liquid chromatography coupled mass spectrometry
LDH	Lactate dehydrogenase (protein symbol)
LGALS3BP	Galectin 3 binding protein (gene / protein symbol)
LRRC15	Leucine rich repeat containing 15 (gene / protein symbol)
LYVE1	Lymphatic Vessel Endothelial Hyaluronan Receptor 1 (gene / protein symbol)

List of abbreviations

M

M	Molar
MAPK	Mitogen-activated protein kinase (protein symbol)
matCAF	Matrix producing cancer-associated fibroblast
MCPC	MCPCOUNTER
mg	Milligramm
min	Minute
mL	Millilitre
mm	Millimeter
mM	Millimolar
MMAE	maytansine or monomethyl auristatin E
MMP	Metalloproteinase
mRNA	messenger ribonucleic acid
ms	Millisecond
MS	Mass spectrometry
myCAF	Myofibroblast cancer-associated fibroblast
m / z	Mass-to-charge ratio

N

n	Sample size
NaCl	Sodium chloride
NANOG	Homeobox transcription factor nanog (gene / protein symbol)
NAT	Normal tissue adjacent to the tumor
NDC	Nanobody drug conjugate
NEAA	Non-essential amino acids
nFB	Normal / non-tumoral fibroblast
ng	Nanogram
NHL	Non-Hodgkin-Lymphoma
NK	Natural killer (cell)

List of abbreviations

NPVM	Non-pulmonary visceral metastasis
NS	Non-seminoma
nm	Nanometer
O	
OS	Overall survival
OCT3 / 4	Octamer-binding transcription factor 3 / 4 (protein symbol)
P	
PA	Polyacrylamide
PBC	Polychlorinated biphenyls
PBS	Phosphate buffered saline
PCA	Principal component analysis
PCI	Phenol / chloroform / isoamyl alcohol
PCR	Polymerase chain reaction
PDPN	Podoplanin (gene / protein symbol)
PEI	Cisplatin + etoposide / VePesid + ifosfamid treatment
PET	Positron emission tomography
PGC	Primordial germ cell
PIN1	Peptidyl-prolyl cis-trans isomerase NIMA-interacting 1 (gene / protein symbol)
PI3K(Cδ)	Phosphoinositide 3-Kinase Cδ (protein symbol)
PLOD	Lysyl hydroxylase
PLOD3	Procollagen-lysine,2-oxoglutarate 5-dioxygenase 3 (protein symbol)
POU5F1	POU domain, Class 5, transcription factor 1 (gene symbol)
PRAME	Preferentially expressed antigen of melanoma (gene / protein symbol)
proCAF	Progenitor cancer-associated fibroblast
PVB	Cisplatin + vinblastine + bleomycin treatment
P / S	Penicillin / Streptomycin

Q

qRT-PCR Quantitative real time polymerase chain reaction

R

RAS Rat sarcoma G-protein (gene / protein symbol)

RHAMM Receptors for hyaluronan mediated motility

RNA Ribonucleic acid

RNAseq RNA sequencing

RPLND Retroperitoneal lymph node dissection

RPMI *Roswell Park Memorial Institute* 1640 medium

RT Room temperature

RTR Residual tumor resection

S

s Second

sc Single cell

scRNAseq Single cell RNA sequencing

SD Standard deviation

SDF-1 Stromal cell derived factor 1 (protein symbol)

SDS Sodium dodecyl sulfate

SDS-PAGE Sodium dodecyl sulfate polyacrylamide gel electrophoresis

SE Seminoma

SLS N-lauroylsarcosine sodium

SOD2 Superoxide dismutase 2 (gene / protein symbol)

SOX2 Sex determining region Y (SRY)-box 2 (gene / protein symbol)

SOX17 Sex determining region Y (SRY)-box 17 (gene / protein symbol)

STAT3 Signal transducer and activator of transcription 3 (gene / protein symbol)

STR Short tandem repeats

List of abbreviations

STRING Search tool for the retrieval of interacting genes / proteins analysis

T

TAGLN Transgelin (gene / protein symbol)

TC Testicular cancer

TCA Trichloroacetic acid

TCGA The Cancer Genome Atlas

TDS Testicular dysgenesis syndrome

TE Teratoma

TEMED Tetramethylethylenediamine

TET Ten-eleven translocation (gene / protein symbol)

TFAP2C Transcription factor AP-2 gamma gene (gene / protein symbol)

TGCT Testicular germ cell tumor

TGFβ1 Transforming growth factor beta 1 (gene / protein symbol)

TIN Testicular intraepithelial neoplasia

TIP Paclitaxel + ifosfamide + cisplatin treatment

TME Tumor microenvironment

TNM Classification for primary tumor, lymph nodes, and metastasis

Tris Tris(hydroxymethyl)aminomethane

TSS Transcription start site

U

U Unit (1 μmol / min)

UICC Union for International Cancer Control

Upreg. Upregulated / Upregulation

UTR Untranslated region

UV Ultraviolet

V

vCAF	Vascular cancer-associated fibroblast
VEGFR	Vascular endothelial growth factor receptor (protein symbol)
VIM	Vimentin (gene / protein symbol)
VIP	Cisplatin + etoposide / VePesid + ifosfamid treatment
V	Volt
v / v	Volume per volume

W

WHO	World Health Organization
WNT5A	Wingless-type MMTV integration site family member 5A (gene / protein symbol)
w / v	Weight per volume

X

XTT	2,3-Bis-(2-methoxy-4-nitro-5-sulfophenyl)-2H-Tetrazolium-5Carboxanilid
-----	--

Y

YST	Yolk-sac tumor
-----	----------------

Others

μL	Microlitre
μm	Micrometer
μM	Micromolar
°C	Degree Celsius
2D	Two-dimensional
3D	Three-dimensional
5mC	5-Methylcytosine

Appendix

Table S1: Affiliation of the GCT-derived CAFs to the subtypes.

Internal names of the different GCT-CAF cultures (SE- / EC- / TE-CAF, and nFB)

CLASSIFICATION	INTERNAL NAME
nFB	MPAF
	LB-C18m
	LB-C35m
	LB-C2-36m
	iLB-C1-30m
SE-CAF	GCT009
	GCT011
	GCT018
	GCT020
	GCT021
	GCT022
EC-CAF	GCT005
	GCT010
	GCT014
TE-CAF	GCT012
	GCT017
	GCT019

Exemplary statistically analyzed RNAseq data of the top 500 upregulated (green), and the top 500 downregulated (red) CpGs in SE-CAFs (n = 6), and NS-CAFs (EC-CAFs = 3, TE-CAFs = 3) in comparison to nFB (n = 5) as logFC and the affiliated gene (if available). FDR < 0.05.

100

Table S4: Proteome data (all factors).

Statistically analyzed proteins of the cellular fraction of in SE-CAFs (n = 6), and NS-CAFs (EC-CAF = 3, TE-CAF = 3) in comparison to nFBs (n = 5) as difference. Student's *t*-test and FDR corrected. Green indicating increase.

SE-CAF vs. nFB					EC-CAF vs. nFB					TE-CAF vs. nFB				
Classification	Genes	Difference	-Log(p-value)	FDR q-value	Classification	Genes	Difference	-Log(p-value)	FDR q-value	Classification	Genes	Difference	-Log(p-value)	FDR q-value
Intracellular	RHO12	0.5	5.2	0.05	Intracellular	FLOT1	1.1	5.9	0.03	Intracellular	SNAPIN	1.7	3.9	0.02
Intracellular	GOT2	0.5	5.4	0.05	Intracellular	NDUF84	1.1	4.7	0.04	Intracellular	PDE5A	1.7	3.7	0.02
Intracellular	HADHB	0.5	4.1	0.05	Intracellular	SCCPDH	1.2	4.2	0.04	Intracellular	FGD4	1.8	2.5	0.05
Intracellular	CHCHD3	0.5	4.3	0.05	Intracellular	HK2	1.2	4.7	0.04	Intracellular	PACSIN3	2.1	3.2	0.03
Intracellular	DNAJC11	0.5	3.3	0.05	Intracellular	HSPD1	1.2	6.3	0.03	Intracellular	STAMBP	2.1	3.2	0.01
Intracellular	ATP5F1B	0.5	4.0	0.05	Intracellular	PDCD4	1.2	3.9	0.04	Intracellular	SORBS2	2.1	2.5	0.03
Intracellular	ATP5F1A	0.5	4.7	0.04	Intracellular	FYCO1	1.3	3.9	0.03	Intracellular	AKAP12	2.3	2.1	0.03
Intracellular	SKIC2	0.5	6.0	0.04	Intracellular	FLOT2	1.3	6.3	0.02	Intracellular	ME3	2.3	4.2	0.01
Intracellular	THRAP3	0.5	3.7	0.05	Intracellular	MCCC1	1.4	2.9	0.04	Intracellular	IRAG1	2.3	3.0	0.01
Intracellular	CEBP2	0.5	4.4	0.04	Intracellular	FDXR	1.4	4.4	0.02	Intracellular	DCLK1	2.4	2.2	0.03
Intracellular	RPS15	0.5	3.1	0.05	Intracellular	ADD1	1.5	4.4	0.02	Intracellular	PNMA2	2.4	4.3	0.01
Intracellular	RBM10	0.5	2.8	0.05	Intracellular	GSDME	1.5	3.2	0.03	Intracellular	SVIL	2.4	3.5	0.01
Intracellular	SMPD4	0.5	2.5	0.05	Intracellular	EML4	1.5	6.3	0.02	Intracellular	CARM1	2.4	4.5	0.02
Intracellular	HUWE1	0.5	3.7	0.04	Intracellular	RCL1	1.5	2.7	0.03	Intracellular	KRT13	2.4	2.6	0.03
Intracellular	BTAF1	0.5	2.7	0.05	Intracellular	ADD3	1.5	4.0	0.02	Intracellular	MYH10	2.5	2.5	0.02
Intracellular	ALDH18A1	0.5	4.2	0.04	Intracellular	JAK1	1.5	4.3	0.02	Intracellular	CAVIN2	2.5	4.7	0.01
Intracellular	DDX24	0.5	3.1	0.05	Intracellular	SARS2	1.5	3.2	0.03	Intracellular	LYRM4	2.7	5.2	0.01
Intracellular	PMPCA	0.5	2.8	0.05	Intracellular	PGM1	1.5	2.9	0.03	Intracellular	PDLIM3	2.8	3.4	0.01
Intracellular	SNMA2	0.5	4.4	0.04	Intracellular	PAPSS2	1.7	3.9	0.02	Intracellular	CONY1	2.8	3.3	0.01
Intracellular	NCL	0.5	4.7	0.04	Intracellular	PACSIN3	1.7	2.8	0.02	Intracellular	PALM	3.2	3.3	0.02
Intracellular	BCLAF1	0.5	3.0	0.04	Intracellular	PNMA2	1.8	3.6	0.02	Intracellular	FHL1	3.2	3.5	0.01
Intracellular	NOP58	0.5	3.4	0.04	Intracellular	OSBP1A	1.8	1.8	0.05	Intracellular	FHL1	3.2	3.5	0.02
Intracellular	OPA1	0.5	5.0	0.04	Intracellular	BMS1	1.8	2.0	0.04	Intracellular	ABAT	3.3	3.0	0.01
Intracellular	HSPA9	0.5	4.0	0.04	Intracellular	SNAPIN	1.8	6.6	0.01	Intracellular	DPYSL2	3.4	4.0	0.01
Intracellular	CNBP	0.5	3.6	0.04	Intracellular	SLC23A2	1.8	3.2	0.02	Intracellular	KRT18	5.1	3.6	0.01
Intracellular	PDHA1	0.6	4.6	0.03	Intracellular	AHR	1.8	2.6	0.02	SIGNAL-peptide	ENG	1.7	3.6	0.03
Intracellular	MOV10	0.6	2.3	0.05	Intracellular	PGM5	1.9	2.3	0.03	SIGNAL-peptide	CPE	1.8	2.5	0.05
Intracellular	ATP1A10	0.6	3.4	0.04	Intracellular	ISYNA1	1.9	2.4	0.02	SIGNAL-peptide	FBN1	1.8	3.1	0.03
Intracellular	NDU5F1	0.6	3.9	0.04	Intracellular	PDE5A	1.9	4.4	0.01	SIGNAL-peptide	IGFBP7	1.8	2.7	0.04
Intracellular	PRPF38A	0.6	2.6	0.04	Intracellular	IBAS7	2.0	1.8	0.04	SIGNAL-peptide	HEG1	1.9	3.6	0.02
Intracellular	OGDH	0.6	5.0	0.03	Intracellular	SVIL	2.0	3.4	0.02	SIGNAL-peptide	CLU	2.0	3.0	0.02
Intracellular	ILKAP	0.6	1.9	0.05	Intracellular	FHL1	2.0	2.0	0.03	SIGNAL-peptide	ROR1	2.1	2.2	0.04
Intracellular	DKC1	0.6	3.7	0.03	Intracellular	RIN3	2.0	3.4	0.02	SIGNAL-peptide	ABCA8	2.3	3.1	0.01
Intracellular	LUC7L3	0.6	2.0	0.05	Intracellular	HSPA12A	2.0	3.3	0.01	SIGNAL-peptide	NOTCH3	2.3	2.3	0.03
Intracellular	PSPC1	0.6	3.1	0.04	Intracellular	RIX1	2.1	2.2	0.02	SIGNAL-peptide	MGP	2.4	2.7	0.02
Intracellular	SKIC3	0.6	5.0	0.03	Intracellular	GATA4	2.1	2.5	0.02	SIGNAL-peptide	PPT2	2.5	1.8	0.04
Intracellular	ATP6V0A1	0.6	2.3	0.04	Intracellular	FHL1	2.1	2.0	0.03	SIGNAL-peptide	BST1	2.5	4.0	0.01
Intracellular	ZRANB2	0.6	3.0	0.04	Intracellular	MDI2	2.2	2.8	0.02	SIGNAL-peptide	LRRC32	2.6	2.1	0.01
Intracellular	LAS1L	0.6	3.5	0.03	Intracellular	DCLK1	2.3	2.0	0.02	SIGNAL-peptide	ADGRL2	2.6	4.0	0.01
Intracellular	RAB13	0.6	3.7	0.03	Intracellular	IRAG1	2.3	3.0	0.01	SIGNAL-peptide	EFEMP1	2.7	2.7	0.01
Intracellular	UTP14A	0.6	1.8	0.05	Intracellular	PYGM	2.5	2.8	0.01	SIGNAL-peptide	SOD3	2.7	3.6	0.01
Intracellular	NFK	0.6	2.8	0.04	Intracellular	FAM162A	2.5	2.6	0.02	SIGNAL-peptide	ITGA7	2.7	2.3	0.02
Intracellular	MRPS11	0.6	2.8	0.04	Intracellular	STAMBP	2.6	3.8	0.01	SIGNAL-peptide	TNKB	3.0	3.7	0.01
Intracellular	TFAM	0.6	3.2	0.04	Intracellular	CYP11A1	2.6	4.5	0.01	SIGNAL-peptide	XPNPEP2	3.1	3.6	0.01
Intracellular	IDH3G	0.6	4.3	0.03	Intracellular	ITPR1	2.6	3.5	0.01	SIGNAL-peptide	MELTF	3.2	1.9	0.02
Intracellular	MRPL28	0.6	2.1	0.05	Intracellular	PHYKPL	2.6	2.0	0.02	SIGNAL-peptide	PTX3	3.3	4.4	0.01
Intracellular	CAND1	0.6	5.9	0.03	Intracellular	CARMIL1	2.7	2.0	0.01	SIGNAL-peptide	IGFBP4	3.4	5.2	0.02
Intracellular	MOC53	0.6	2.3	0.04	Intracellular	AOX1	2.8	2.8	0.01	SIGNAL-peptide	PLAT	4.5	3.5	0.01
Intracellular	G6PD	0.6	2.5	0.04	Intracellular	DES	2.8	2.0	0.02	SIGNAL-peptide	PTGIS	4.5	4.1	0.02
Intracellular	TIMM50	0.6	3.8	0.03	Intracellular	MAOB	2.8	4.4	0.01	Transmembrane	CYP11B1	2.1	2.4	0.03
Intracellular	HNRNP1	0.6	3.7	0.03	Intracellular	PALMD	2.8	3.8	0.01	Transmembrane	PTGES	2.4	3.3	0.01
Intracellular	PPAT	0.6	2.0	0.04	Intracellular	LACC1	2.9	3.0	0.01	Transmembrane	DAGLB	2.4	4.0	0.01
Intracellular	MRPL58	0.6	4.0	0.03	Intracellular	ACSS1	2.9	2.6	0.01	Transmembrane	SLC6A6	3.0	2.1	0.02
Intracellular	NOP10	0.6	2.0	0.04	Intracellular	STXBP2	2.9	3.1	0.01	Transmembrane	MEST	4.0	4.7	0.02
Intracellular	MRPL38	0.6	4.9	0.03	Intracellular	ME3	3.0	5.7	0.01	UPS	S100A10	1.8	4.1	0.02
Intracellular	PEK1	0.6	3.4	0.03	Intracellular	FKBP5	3.1	4.1	0.01	UPS	ANXA10	2.2	2.1	0.04
Intracellular	NOP2	0.6	2.7	0.04	Intracellular	KRT13	3.1	1.6	0.02	UPS	PLA2G4A	2.3	2.8	0.02
Intracellular	TEX10	0.6	4.0	0.03	Intracellular	PALM	3.3	3.2	0.01	UPS	SLC25A4	2.3	4.4	0.01
Intracellular	MRPS23	0.6	5.6	0.03	Intracellular	CCNYL1	3.4	3.6	0.01	UPS	MAPRE2	2.6	2.7	0.01
Intracellular	LRPPRC	0.6	5.6	0.03	Intracellular	PDLIM3	3.4	3.4	0.01	UPS	GNNG12	2.7	4.1	0.01
Intracellular	FBI	0.6	4.3	0.03	Intracellular	CAVIN2	3.4	5.3	0.02	UPS	LXN	2.7	1.8	0.04
Intracellular	ZC3HC1	0.6	2.6	0.03	Intracellular	DPYSL2	3.8	3.8	0.01	UPS	MEDGA	2.8	2.7	0.01
Intracellular	VPS37A	0.6	2.1	0.04	Intracellular	ABAT	4.4	4.1	0.01	UPS	ANXA3	3.4	3.4	0.02
Intracellular	CHP1	0.6	2.8	0.03	Intracellular	KRT18	4.4	3.2	0.01	UPS	FABP3	4.1	4.4	0.01
Intracellular	RRP1	0.6	4.0	0.03	SIGNAL-peptide	H6PD	1.4	3.2	0.03	UPS	TP5311	5.1	4.7	0.02
Intracellular	PDXP	0.6	3.7	0.03	SIGNAL-peptide	AGA	1.5	2.5	0.04	UPS	ADH1B	6.6	4.3	0.00
Intracellular	ASAP1	0.6	2.8	0.03	SIGNAL-peptide	CES2	1.5	5.5	0.03					
Intracellular	CUX1	0.6	1.6	0.05	SIGNAL-peptide	ROR1	1.6	2.3	0.04					
Intracellular	BRIX1	0.6	2.3	0.04	SIGNAL-peptide	CACNA2D1	1.6	3.6	0.02					
Intracellular	WDR12	0.6	2.7	0.03	SIGNAL-peptide	LRN4C1	1.6	2.8	0.03					
Intracellular	STAT3	0.6	2.6	0.03	SIGNAL-peptide	CTSA	1.6	3.8	0.03					
Intracellular	ACOX2	0.6	2.4	0.04	SIGNAL-peptide	ROR2	1.6	2.8	0.03					
Intracellular	MTX1	0.6	5.9	0.02	SIGNAL-peptide	PTGFRN	1.7	3.8	0.02					
Intracellular	UCR8B	0.6	3.8	0.03	SIGNAL-peptide	CCDC80	1.7	2.5	0.03					
Intracellular	MRPS7	0.6	4.7	0.02	SIGNAL-peptide	NID2	1.7	2.2	0.03					
Intracellular	NFS1	0.6	3.6	0.03	SIGNAL-peptide	ADGRL2	1.8	2.8	0.02					
Intracellular	SPART	0.6	2.8	0.03	SIGNAL-peptide	TIMP1	1.8	3.0	0.02					
Intracellular	SHMT2	0.6	3.8	0.03	SIGNAL-peptide	NRP2	1.9	2.7	0.02					
Intracellular	SAMM50	0.6	3.8	0.03	SIGNAL-peptide	ENG	1.9	3.7	0.01					
Intracellular	MRP1	0.6	3.6	0.03	SIGNAL-peptide	LRRC32	1.9	2.1	0.03					
Intracellular	MECP2	0.6	2.1	0.04	SIGNAL-peptide	IGFBP7	2.0	2.8	0.02					
Intracellular	MRPS15	0.6	3.9	0.03	SIGNAL-peptide	FBN1	2.0	3.4	0.01					
Intracellular	PMPCB	0.6	4.3	0.02	SIGNAL-peptide	MXRA7	2.0	3.8	0.01					
Intracellular	NIPSNAP2	0.6	2.8	0.03	SIGNAL-peptide	CFM	2.1	1.7	0.04					
Intracellular	GTF3C2	0.6	1.4											

Intracellular	RHBDF1	0.7	3.5	0.02	Transmembrane	AADAC	4.7	4.4	0.00
Intracellular	DLD	0.7	5.8	0.01	UPS	AK2	1.1	5.0	0.05
Intracellular	EBNA1BP2	0.7	3.4	0.02	UPS	HSPE1	1.2	4.3	0.04
Intracellular	CPOX	0.7	4.7	0.01	UPS	PTRHD1	1.4	3.0	0.03
Intracellular	ABC4	0.7	1.8	0.03	UPS	S100A10	1.5	3.0	0.03
Intracellular	CAMK2D	0.7	6.4	0.01	UPS	ABHD10	1.6	2.5	0.03
Intracellular	SUCLA2	0.7	6.0	0.01	UPS	CDC40	1.6	2.2	0.04
Intracellular	MTHFD1L	0.7	3.9	0.02	UPS	PIA2G4A	1.6	2.2	0.04
Intracellular	TRAP1	0.7	3.6	0.02	UPS	SLC25A4	1.6	4.0	0.02
Intracellular	SH2D4A	0.7	1.5	0.03	UPS	MFJ	1.6	3.6	0.02
Intracellular	JARS2	0.7	4.8	0.01	UPS	SELENBP1	2.2	3.8	0.01
Intracellular	ZNF326	0.7	3.6	0.02	UPS	ANXA10	2.2	3.2	0.01
Intracellular	TRMT1L	0.7	1.1	0.04	UPS	LYPLAL1	2.4	2.0	0.02
Intracellular	FRMD8	0.7	4.0	0.02	UPS	ACSS3	2.5	2.3	0.02
Intracellular	AFG3L2	0.7	3.7	0.02	UPS	CNG3	2.7	4.1	0.01
Intracellular	TP53BP1	0.7	4.5	0.01	UPS	OPRT	2.7	3.2	0.01
Intracellular	DNAJA3	0.7	5.2	0.01	UPS	ADH1B	2.9	3.6	0.01
Intracellular	FILIP1L	0.7	0.9	0.05	UPS	ADH1C	3.3	3.6	0.01
Intracellular	BLOC1	0.7	3.1	0.02	UPS	FBP1	3.3	4.6	0.01
Intracellular	EGLN1	0.8	4.4	0.01	UPS	ALDH1A1	3.7	1.6	0.02
Intracellular	PLIN2	0.8	2.6	0.02	UPS	HNMT	3.9	4.5	0.02
Intracellular	WARS2	0.8	2.6	0.02	UPS	ANXA3	4.1	3.7	0.01
Intracellular	MRPL11	0.8	3.7	0.01	UPS	IL33	4.7	3.8	0.02
Intracellular	SLRP	0.8	4.5	0.01	UPS	TP53I11	5.1	4.3	0.00
Intracellular	ACA11	0.8	4.3	0.01	UPS	LXM	5.3	3.3	0.01
Intracellular	MRPL15	0.8	3.7	0.01	UPS	STAR	5.9	5.9	0.00

Intracellular	SSBP1	0.8	5.6	0.01	Intracellular	PDPR	1.1	5.8	0.00	Intracellular	PALMD	2.9	5.6	0.00
Intracellular	SURF6	0.8	1.3	0.03	Intracellular	NELFA	1.1	1.6	0.01	Intracellular	ACSS1	2.9	4.1	0.00
Intracellular	TUFM	0.8	5.3	0.01	Intracellular	MRP55	1.1	2.4	0.01	Intracellular	STXBP2	2.9	5.1	0.00
Intracellular	MSU2	1.6	1.1	0.03	Intracellular	NSNAP1	1.1	3.5	0.00	Intracellular	FKBP2	2.9	6.3	0.00
Intracellular	NADSYN1	0.8	1.7	0.03	Intracellular	TRMT10C	1.1	4.1	0.00	Intracellular	ME3	3.0	3.7	0.00
Intracellular	PYGL	0.8	3.2	0.02	Intracellular	BCKDHA	1.1	3.7	0.00	Intracellular	LAC2	3.0	7.9	0.00
Intracellular	RBM26	0.8	2.2	0.02	Intracellular	NTSDC1	1.1	1.4	0.01	Intracellular	SRSF2	3.0	1.2	0.00
Intracellular	DAP3	0.8	5.3	0.01	Intracellular	PDCD4	1.1	7.7	0.00	Intracellular	CARTL1	3.0	7.4	0.00
Intracellular	PALS2	0.8	2.1	0.02	Intracellular	COTX7A2	1.1	3.9	0.00	Intracellular	PALM	3.3	5.3	0.00
Intracellular	SPRYD4	0.8	4.1	0.01	Intracellular	NDUFAF2	1.1	2.2	0.01	Intracellular	PDLM3	3.4	5.3	0.00
Intracellular	NOL9	0.8	4.6	0.01	Intracellular	PCCA	1.1	4.0	0.00	Intracellular	DEF5	3.5	2.8	0.00
Intracellular	CASK	0.8	3.8	0.01	Intracellular	AASS	1.1	1.6	0.01	Intracellular	CANX2	3.5	9.6	0.01
Intracellular	NNT	0.8	3.5	0.01	Intracellular	HDH3	1.1	2.9	0.01	Intracellular	CNNY1	3.7	5.3	0.00
Intracellular	WDR91	0.8	3.2	0.01	Intracellular	SMAD3	1.1	3.1	0.01	Intracellular	DPYSL2	3.9	6.2	0.00
Intracellular	HSPA4L	0.8	2.1	0.02	Intracellular	GTF3C2	1.1	2.4	0.01	Intracellular	ABAT	4.5	6.6	0.00
Intracellular	TRIM47	0.9	0.5	0.05	Intracellular	MRP52	1.1	0.7	0.03	Intracellular	KRT18	4.7	2.3	0.00
Intracellular	HEXIM1	0.8	2.0	0.02	Intracellular	HSPD1	1.1	7.0	0.00	Signal-peptide	AGPAT1	0.5	2.8	0.05
Intracellular	COG7	0.8	1.0	0.04	Intracellular	SCCPDH	1.1	5.7	0.00	Signal-peptide	MRPS22	0.5	3.4	0.05
Intracellular	GFM2	0.8	1.5	0.03	Intracellular	MRPL4	1.1	1.2	0.02	Signal-peptide	HYOU1	0.5	2.8	0.04
Intracellular	GPI	0.8	4.4	0.01	Intracellular	BET1L	1.2	1.6	0.01	Signal-peptide	TPBG	0.6	3.6	0.03
Intracellular	SVNPO	0.8	1.2	0.04	Intracellular	MTIF2	1.2	2.4	0.00	Signal-peptide	PHH1	0.6	4.4	0.03
Intracellular	SHB	0.8	2.4	0.02	Intracellular	NDUFB4	1.2	6.2	0.00	Signal-peptide	ADAM17	0.6	4.4	0.03
Intracellular	TIMM22	0.8	1.4	0.03	Intracellular	BCL2L13	1.2	4.9	0.00	Signal-peptide	OSOX1	0.6	4.0	0.03
Intracellular	ATM	0.8	4.7	0.01	Intracellular	NDUFB11	1.2	3.3	0.00	Signal-peptide	RET SAT	0.6	2.6	0.03
Intracellular	PC	0.8	3.7	0.01	Intracellular	SAP18	1.2	2.2	0.01	Signal-peptide	JAM3	0.6	2.2	0.04
Intracellular	NDUF810	0.8	3.2	0.01	Intracellular	CP3H18	1.2	2.2	0.01	Signal-peptide	MB2D2	0.6	2.6	0.03
Intracellular	SUPV3L1	0.8	4.3	0.01	Intracellular	PPM1B	1.2	3.8	0.00	Signal-peptide	EGRF	0.6	2.9	0.03
Intracellular	MAP4	0.8	2.5	0.02	Intracellular	SERPINB9	1.2	3.6	0.00	Signal-peptide	POGLUT2	0.6	2.1	0.03
Intracellular	LARS2	0.9	0.9	0.04	Intracellular	CASP1	1.2	1.3	0.03	Signal-peptide	DNASE2	0.6	2.6	0.03
Intracellular	SRSF4	0.8	2.1	0.02	Intracellular	CAPN5	1.2	4.4	0.00	Signal-peptide	PHF14	0.7	2.5	0.03
Intracellular	ALDH9A1	0.8	2.8	0.01	Intracellular	MAN2C1	1.2	0.9	0.03	Signal-peptide	SLC39A14	0.7	2.1	0.03
Intracellular	EC1	0.8	2.4	0.02	Intracellular	ALDH2	1.2	3.5	0.00	Signal-peptide	DNALC1	0.7	2.1	0.03
Intracellular	HSPB86	0.9	0.9	0.04	Intracellular	ABI2	1.2	2.0	0.03	Signal-peptide	CFP	0.7		

Appendix

SIGNAL-PEPTIDE	AGPAT1	0.5	2.8	0.05	Transmembrane	SLC35F6	0.7	3.7	0.02	UPS	MRPS27	0.9	3.1	0.01
SIGNAL-PEPTIDE	MRPS22	0.5	3.4	0.05	Transmembrane	TMEM16A	0.7	4.7	0.02	UPS	NOL11	0.9	1.8	0.02
SIGNAL-PEPTIDE	HYOU1	0.5	2.8	0.05	Transmembrane	ABCC1	0.7	4.1	0.02	UPS	PSMB9	0.9	1.2	0.03
SIGNAL-PEPTIDE	TPBG	0.6	3.6	0.03	Transmembrane	PGAM5	0.7	4.5	0.01	UPS	MTCH2	0.9	6.7	0.01
SIGNAL-PEPTIDE	CTSL	0.6	3.4	0.03	Transmembrane	HADH	0.7	3.7	0.02	UPS	GYG1	0.9	3.4	0.01
SIGNAL-PEPTIDE	ADAM17	0.6	4.4	0.03	Transmembrane	FRG1	0.7	4.0	0.01	UPS	ATPM3	0.9	3.5	0.01
SIGNAL-PEPTIDE	QSOX1	0.6	4.0	0.03	Transmembrane	NDUF4	0.7	3.8	0.02	UPS	SLC35A4	0.9	4.3	0.01
SIGNAL-PEPTIDE	RETSAT	0.6	2.6	0.03	Transmembrane	DPY19L3	0.8	1.9	0.03	UPS	ISOC1	0.9	2.2	0.01
SIGNAL-PEPTIDE	JAM3	0.6	2.2	0.04	Transmembrane	EXOG	0.8	1.0	0.04	UPS	TMEM65	0.9	1.7	0.02
SIGNAL-PEPTIDE	GST3	0.6	2.6	0.03	Transmembrane	TMEM97	0.8	1.4	0.03	UPS	MARCHF5	0.9	2.3	0.01
SIGNAL-PEPTIDE	EGFR	0.6	2.9	0.03	Transmembrane	RRC5A	0.8	1.1	0.04	UPS	VDAC3	0.9	4.2	0.01
SIGNAL-PEPTIDE	POGLUT2	0.6	2.1	0.03	Transmembrane	SLC25A3	0.8	2.6	0.02	UPS	RBPMS	0.9	5.2	0.01
SIGNAL-PEPTIDE	DNASE2	0.6	2.6	0.03	Transmembrane	GOLM1	0.8	2.6	0.01	UPS	SNUI3	1.0	4.1	0.01
SIGNAL-PEPTIDE	PAHA1	0.7	2.5	0.03	Transmembrane	CDC127	0.8	1.4	0.03	UPS	CYCS	1.0	5.5	0.01
SIGNAL-PEPTIDE	SLC39A14	0.7	2.1	0.03	Transmembrane	SLC25A22	0.8	4.6	0.01	UPS	HIBADH	1.0	2.9	0.01
SIGNAL-PEPTIDE	DNAJC1	0.7	2.1	0.03	Transmembrane	OCD1	0.9	5.9	0.01	UPS	SDSL	1.0	2.0	0.01
SIGNAL-PEPTIDE	CPO	0.7	2.4	0.03	Transmembrane	FAP	0.9	2.0	0.02	UPS	HCCS	1.0	2.6	0.01
SIGNAL-PEPTIDE	MAN2B2	0.7	1.7	0.03	Transmembrane	GDE1	0.9	3.0	0.01	UPS	ATPAF1	1.0	2.8	0.01
SIGNAL-PEPTIDE	CTBS	0.7	1.2	0.04	Transmembrane	SLC44A2	0.9	2.1	0.02	UPS	NIF7	1.0	0.7	0.04
SIGNAL-PEPTIDE	AGRN	0.7	1.0	0.05	Transmembrane	GAA	0.9	1.4	0.02	UPS	SOOR	1.0	3.4	0.01
SIGNAL-PEPTIDE	EFNB1	0.8	1.2	0.04	Transmembrane	SLC16A1	0.9	4.3	0.01	UPS	PPIF	1.0	3.5	0.01
SIGNAL-PEPTIDE	CHID1	0.8	4.5	0.01	Transmembrane	WLS	0.9	2.2	0.01	UPS	AK2	1.0	5.3	0.00
SIGNAL-PEPTIDE	GM2A	0.8	1.4	0.03	Transmembrane	UQCRC	0.9	2.8	0.01	UPS	HEBP1	1.0	5.1	0.01
SIGNAL-PEPTIDE	MIFGE8	0.8	1.7	0.03	Transmembrane	ATP1B1	1.0	3.4	0.01	UPS	ZNF346	1.0	2.3	0.01
SIGNAL-PEPTIDE	FCGR1	0.8	1.5	0.03	Transmembrane	NTN1	1.0	6.3	0.00	UPS	APOO	1.0	5.7	0.00
SIGNAL-PEPTIDE	CD46	0.8	2.3	0.02	Transmembrane	MAN1A	1.0	1.0	0.02	UPS	HSPF1	1.0	5.0	0.00
SIGNAL-PEPTIDE	SPATA20	0.8	3.8	0.01	Transmembrane	SELENO5	1.0	4.4	0.02	UPS	PLSGR1	1.0	5.2	0.00
SIGNAL-PEPTIDE	MAN2B1	0.8	3.5	0.01	Transmembrane	STOM	1.1	2.6	0.01	UPS	NDUF4F	1.1	3.5	0.00
SIGNAL-PEPTIDE	GLMP	0.8	1.9	0.02	Transmembrane	SYNGR2	1.1	0.8	0.03	UPS	SPG21	1.1	1.1	0.02
SIGNAL-PEPTIDE	PRCP	0.8	2.3	0.02	Transmembrane	PTDS2	1.2	0.9	0.02	UPS	HSD17B10	1.1	6.2	0.00
SIGNAL-PEPTIDE	LAMP2	0.8	2.1	0.02	Transmembrane	SLC3A1	1.2	2.2	0.01	UPS	PREP1	1.1	2.9	0.00
SIGNAL-PEPTIDE	OS9	0.8	3.5	0.01	Transmembrane	EPDR1	1.2	1.3	0.01	UPS	THYN1	1.1	1.6	0.01
SIGNAL-PEPTIDE	NAGLU	0.9	3.5	0.01	Transmembrane	ITM2B	1.2	1.7	0.01	UPS	NPM3	1.1	1.8	0.01
SIGNAL-PEPTIDE	OSMR	0.9	1.8	0.02	Transmembrane	TMEM192	1.2	1.2	0.01	UPS	TOMM40	1.2	3.4	0.00
SIGNAL-PEPTIDE	SYNGR1	0.9	1.4	0.04	Transmembrane	LPCAT3	1.2	2.1	0.01	UPS	FOH1	1.2	5.2	0.00
SIGNAL-PEPTIDE	LGMM	0.9	3.1	0.01	Transmembrane	CYND2B	1.2	3.2	0.00	UPS	CIOBP	1.2	4.9	0.00
SIGNAL-PEPTIDE	LTBP3	0.9	1.8	0.02	Transmembrane	PLD3	1.3	3.8	0.00	UPS	UBE2L6	1.2	1.3	0.01
SIGNAL-PEPTIDE	PCYOX1	0.9	3.7	0.01	Transmembrane	DHODH	1.3	3.5	0.00	UPS	PTRH1	1.2	3.2	0.00
SIGNAL-PEPTIDE	CACNA1D	0.9	4.1	0.01	Transmembrane	COL4A2	1.3	2.3	0.01	UPS	HSDL2	1.3	6.6	0.00
SIGNAL-PEPTIDE	GLA	0.9	1.6	0.02	Transmembrane	CGAL11	1.3	3.9	0.00	UPS	NAT1	1.3	1.1	0.00
SIGNAL-PEPTIDE	GNPMB	0.9	0.9	0.03	Transmembrane	NEU1	1.4	3.9	0.00	UPS	AK3	1.3	4.7	0.00
SIGNAL-PEPTIDE	MCU	0.9	3.9	0.01	Transmembrane	CD82	1.4	1.4	0.01	UPS	CEBPB	1.3	4.4	0.00
SIGNAL-PEPTIDE	SEMA3C	0.9	1.5	0.02	Transmembrane	ABCA6	1.4	3.3	0.00	UPS	CISD1	1.3	2.3	0.01
SIGNAL-PEPTIDE	HLA-C	0.9	0.7	0.03	Transmembrane	SLC2A5	1.5	4.3	0.00	UPS	TMEM70	1.3	4.0	0.01
SIGNAL-PEPTIDE	SLC30A1	0.9	4.4	0.01	Transmembrane	COA3	1.5	5.4	0.00	UPS	AKR1C3	1.4	3.1	0.00
SIGNAL-PEPTIDE	PTPRA	0.9	4.9	0.01	Transmembrane	COX6C	1.6	6.3	0.00	UPS	GSTM3	1.4	2.6	0.00
SIGNAL-PEPTIDE	HEXA	1.0	3.4	0.01	Transmembrane	PTGES	1.6	2.5	0.00	UPS	SOD2	1.4	1.8	0.01
SIGNAL-PEPTIDE	TAPBP1	1.0	1.1	0.03	Transmembrane	CGC2	1.6	2.3	0.00	UPS	PSM10	1.4	1.9	0.01
SIGNAL-PEPTIDE	ASAHI	1.0	2.3	0.01	Transmembrane	STR6A	1.6	3.7	0.00	UPS	S100A10	1.4	5.0	0.00
SIGNAL-PEPTIDE	CNPY3	1.0	0.9	0.03	Transmembrane	EPHX1	1.6	5.8	0.00	UPS	ERMP1	1.4	3.0	0.00
SIGNAL-PEPTIDE	CPM	1.0	1.1	0.03	Transmembrane	ARMC10	1.7	4.1	0.00	UPS	TFR	1.5	6.9	0.00
SIGNAL-PEPTIDE	IGFBP2	1.0	5.0	0.00	Transmembrane	PLD2	1.7	4.0	0.00	UPS	MIF	1.5	3.2	0.00
SIGNAL-PEPTIDE	IDUA	1.0	2.5	0.01	Transmembrane	ACSL5	1.7	2.3	0.00	UPS	AKR1C2	1.5	3.0	0.00
SIGNAL-PEPTIDE	ADAM9	1.0	4.4	0.00	Transmembrane	DHRS3	1.7	1.7	0.00	UPS	SLC25A4	1.6	5.2	0.00
SIGNAL-PEPTIDE	SLAE	1.1	3.2	0.01	Transmembrane	METTL7A	1.8	4.6	0.00	UPS	MEDAG	1.6	2.4	0.00
SIGNAL-PEPTIDE	CTSD	1.1	4.2	0.01	Transmembrane	LRRC8D	1.8	5.2	0.00	UPS	ABHD10	1.6	4.1	0.00
SIGNAL-PEPTIDE	NOTCH3	1.1	1.6	0.01	Transmembrane	GALNT1	1.8	1.3	0.00	UPS	CASB	1.6	1.9	0.00
SIGNAL-PEPTIDE	ACVR1	1.1	2.1	0.01	Transmembrane	CD9	1.9	2.9	0.00	UPS	CD40	1.6	3.7	0.00
SIGNAL-PEPTIDE	TPP1	1.1	3.6	0.00	Transmembrane	SCD5	2.0	4.8	0.00	UPS	HACL1	1.6	1.3	0.01
SIGNAL-PEPTIDE	BTBA3	1.1	2.8	0.01	Transmembrane	CEMP1	2.1	2.8	0.00	UPS	SET	1.6	0.9	0.02
SIGNAL-PEPTIDE	GNS	1.1	3.0	0.01	Transmembrane	SYNGR1	2.1	2.7	0.00	UPS	TIMM9	1.7	2.7	0.00
SIGNAL-PEPTIDE	CPZ	1.2	1.9	0.01	Transmembrane	CYP1B1	2.3	4.3	0.00	UPS	ACOT13	1.7	1.7	0.00
SIGNAL-PEPTIDE	GES2	1.2	3.6	0.00	Transmembrane	DHCR24	2.3	2.4	0.00	UPS	AK4	1.7	1.3	0.01
SIGNAL-PEPTIDE	LAMA1	1.2	3.6	0.00	Transmembrane	GGT5	2.3	2.5	0.00	UPS	RBX1	1.8	1.2	0.01
SIGNAL-PEPTIDE	MANBA	1.2	1.6	0.01	Transmembrane	SYLP2	2.4	3.9	0.00	UPS	DGLUCY	1.9	4.2	0.00
SIGNAL-PEPTIDE	PSAP	1.2	3.1	0.00	Transmembrane	ABCA9	2.8	5.9	0.00	UPS	ANXA10	2.1	3.9	0.00
SIGNAL-PEPTIDE	LAMA4	1.2	1.8	0.01	Transmembrane	SCARA5	2.9	4.4	0.00	UPS	LYPLAL1	2.3	3.0	0.00
SIGNAL-PEPTIDE	CD220	1.2	2.6	0.01	Transmembrane	HS2ST1	2.9	6.9	0.00	UPS	PLA2G4A	2.3	5.1	0.00
SIGNAL-PEPTIDE	FUCP2	1.2	1.5	0.01	Transmembrane	DAGLB	3.0	7.2	0.00	UPS	SELENBP1	2.4	3.8	0.00
SIGNAL-PEPTIDE	CFB	1.3	1.8	0.01	Transmembrane	CYB561A3	3.0	3.9	0.00	UPS	BTF3L4	2.4	1.1	0.01
SIGNAL-PEPTIDE	CFH	1.3	2.7	0.00	Transmembrane	DP4	3.2	5.0	0.00	UPS	GN3L2	2.5	6.3	0.00
SIGNAL-PEPTIDE	COL8A1	1.3	3.6	0.00	Transmembrane	TSPAN8	3.4	5.2	0.00	UPS	MAPRE2	2.5	5.6	0.00
SIGNAL-PEPTIDE	MYRAT	1.3	3.3	0.00	Transmembrane	MEST	3.5	4.9	0.00	UPS	ACSS3	2.7	4.0	0.00
SIGNAL-PEPTIDE	ERAP1	1.3	2.6	0.00	Transmembrane	ADAC	3.5	4.4	0.00	UPS	ADH1C	2.8	2.5	0.00
SIGNAL-PEPTIDE	TLR3	1.3	2.1	0.01	Transmembrane	BS2	4.0	4.2	0.00	UPS	ADH1B	2.9	1.8	0.00
SIGNAL-PEPTIDE	NENF	1.3	0.6	0.04	UPS	IDH3A	0.5	4.0	0.05	UPS	FABP3	3.1	2.8	0.00
SIGNAL-PEPTIDE	QUSB	1.3	3.8	0.00	UPS	ATP5F1C	0.5	3.7	0.05	UPS	OPRT	3.4	5.9	0.00
SIGNAL-PEPTIDE	FAM20B	1.4	1.9	0.01	UPS	MRFR	0.5	3.7	0.05	UPS	FBP1	3.4	5.1	0.00
SIGNAL-PEPTIDE	F3	1.4	2.8	0.00	UPS	ATP5P0	0.5	5.0	0.04	UPS	ALDH1A1	4.0	2.8	0.00
SIGNAL-PEPTIDE	ATRN	1.5	1.5	0.01	UPS	CS	0.5	4.5	0.04	UPS	HNMT	4.2	7.5	0.00
SIGNAL-PEPTIDE	PTGFRN	1.5	4.8	0.00	UPS	ATP5F1D	0.5	4.5	0.04	UPS	ANXA3	5.1	6.4	0.00
SIGNAL-PEPTIDE	H6PD	1.5	4.7	0.00	UPS	VDAC1	0.5	2.9	0.05	UPS	LXN	5.1	4.7	0.00
SIGNAL-PEPTIDE	BST1	1.5	3.8	0.00	UPS	PH	0.5	3.5	0.05	UPS	TP5311	5.2	6.2	0.00
SIGNAL-PEPTIDE	LRRC2	1.6	2.3	0.00	UPS	TSFM	0.5	2.5	0.05	UPS	IL33	5.4	6.4	0.00
SIGNAL-PEPTIDE	CADM4	1.6	2.2	0.00	UPS	NANS	0.5	2.9	0.05	UPS	STAR	6.2	8.0	0.00
SIGNAL-PEPTIDE	MGP	1.6	1.5	0.01	UPS	COX41	0.5	3.6	0.04					
SIGNAL-PEPTIDE	GALC	1.6	2.3	0.00	UPS	ETFB	0.5	3.2	0.04					
SIGNAL-PEPTIDE	ITGB3	1.6	2.9	0.00	UPS	PDHB	0.5	3.9	0.04					
SIGNAL-PEPTIDE	IL13RA2	1.6	1.7	0.01	UPS	HEATR1	0.6	2.6	0.04					
SIGNAL-PEPTIDE	HEG1	1.6	4.8	0.00	UPS	SCP2	0.6	3.9	0.04					
SIGNAL-PEPTIDE	ROR1	1.6	3.4	0.00	UPS	APEX	0.6	3.8	0.04					
SIGNAL-PEPTIDE	TPST1	1.6	2.8	0.00	UPS	DECR1	0.6	2.7	0.04					
SIGNAL-PEPTIDE	IGFSA	1.6	3.6	0.00	UPS	ADH5	0.6	2.7	0.04					
SIGNAL-PEPTIDE	C1S	1.6	3.5	0.00	UPS	MRPL39	0.6	2.5	0.04					
SIGNAL-PEPTIDE	LRN4CL	1.7	4.7	0.00	UPS	PHF	0.6	4.6	0.03					
SIGNAL-PEPTIDE	NDU2	1.7	3.8	0.00	UPS	ATP5PD	0.6	2.6	0.04					
SIGNAL-PEPTIDE	ENG	1.7	4.7	0.00	UPS	ISOC2	0.6	3.7	0.03					
SIGNAL-PEPTIDE	NRP2	1.7	4.0	0.00	UPS	MRPL1	0.6	2.7	0.03					
SIGNAL-PEPTIDE	ITGA7	1.8	2.2	0.00										

Table S5: Secretome data (all factors).

Statistically analyzed secreted factors of in SE-CAFs (n = 6), and NS-CAFs (EC-CAF = 3, TE-CAF = 3) in comparison to nFBs (n = 5) as difference. Student's *t*-test and FDR corrected.

SE-CAF vs. nFB					EC-CAF vs. nFB					TE-CAF vs. nFB				
Classification	Genes	Difference	-Log(p-value)	FDR	Classification	Genes	Difference	-Log(p-value)	FDR	Classification	Genes	Difference	-Log(p-value)	FDR
Signal-peptide	BST1	1.1	1.9	0.04	Signal-peptide	C1RL	2.1	2.9	0.02	Signal-peptide	ABI3BP	2.4	2.5	0.04
Signal-peptide	SEMA4B	1.2	2.3	0.03	Signal-peptide	PLAT	2.2	2.2	0.05	Signal-peptide	BCAM	2.5	3.2	0.03
Signal-peptide	GES2	1.2	1.6	0.05	Signal-peptide	CTSH	2.4	2.8	0.02	Signal-peptide	AGT	2.7	2.4	0.04
Signal-peptide	HSPD	1.2	3.6	0.01	Signal-peptide	SEZ6L2	2.4	4.2	0.01	Signal-peptide	BST1	2.8	3.6	0.02
Signal-peptide	FBLN2	1.3	2.5	0.02	Signal-peptide	ROR1	2.5	2.1	0.04	Signal-peptide	PLAT	2.8	2.7	0.03
Signal-peptide	PPT2	1.3	1.8	0.03	Signal-peptide	VCAM1	2.5	3.0	0.01	Signal-peptide	ADAMTS1	2.9	2.8	0.03
Signal-peptide	LAMP2	1.3	2.9	0.01	Signal-peptide	C4A	2.6	2.5	0.02	Signal-peptide	CPA4	3.0	4.5	0.01
Signal-peptide	CTSH	1.3	2.0	0.02	Signal-peptide	IL6ST	2.7	3.5	0.01	Signal-peptide	IL6	3.0	2.7	0.02
Signal-peptide	PRSS23	1.4	1.3	0.04	Signal-peptide	FBLN2	2.7	2.4	0.02	Signal-peptide	IGFBP5	3.1	2.9	0.02
Signal-peptide	DDR1	1.4	1.4	0.04	Signal-peptide	PROS1	2.8	2.2	0.02	Signal-peptide	ADGRG6	3.2	3.4	0.02
Signal-peptide	EFEMP1	1.4	1.4	0.04	Signal-peptide	ADAM9	2.9	2.2	0.02	Signal-peptide	RARRES1	3.3	3.3	0.02
Signal-peptide	QSOX2	1.5	1.4	0.03	Signal-peptide	CPE	3.2	2.6	0.01	Signal-peptide	PAPPA2	3.4	2.3	0.03
Signal-peptide	TIMP1	1.6	3.0	0.01	Signal-peptide	CPA4	3.2	3.8	0.01	Signal-peptide	CPE	3.5	3.0	0.01
Signal-peptide	PLAT	1.6	2.2	0.01	Signal-peptide	LGALS3BP	3.2	1.9	0.03	Signal-peptide	PTX3	3.9	3.0	0.02
Signal-peptide	TFF1	1.7	2.2	0.01	Signal-peptide	PAPPA2	3.3	2.6	0.01	Signal-peptide	PCSK9	3.9	2.8	0.02
Signal-peptide	ND2	1.7	2.4	0.01	Signal-peptide	PLTP	3.3	4.1	0.01	Signal-peptide	SRGN	4.0	4.0	0.03
Signal-peptide	PROS1	1.7	2.2	0.01	Signal-peptide	TMEM130	3.4	2.4	0.01	Signal-peptide	PRG2	4.0	3.9	0.02
Signal-peptide	ROR1	1.8	2.4	0.01	Signal-peptide	A2M	3.4	2.3	0.01	Signal-peptide	SCRG1	4.3	2.2	0.02
Signal-peptide	ADAM9	1.8	1.7	0.01	Signal-peptide	BMP1	3.4	2.0	0.02	Signal-peptide	IGFBP1	4.6	3.1	0.02
Signal-peptide	LGALS3BP	1.9	1.9	0.01	Signal-peptide	BCAM	3.5	3.0	0.01	Signal-peptide	CST2	4.7	2.9	0.01
Signal-peptide	C3	1.9	1.5	0.02	Signal-peptide	CLU	3.7	2.4	0.01	UPS	FABP3	3.3	3.4	0.02
Signal-peptide	BMP1	1.9	1.9	0.01	Signal-peptide	PTX3	4.0	3.5	0.01	UPS	ANXA10	4.9	3.5	0.05
Signal-peptide	SEZ6L2	1.9	2.7	0.00	Signal-peptide	SCRG1	4.1	1.8	0.02	UPS	ADH1B	6.4	4.1	0.00
Signal-peptide	PAPPA2	2.0	1.8	0.01	Signal-peptide	SRGN	4.1	2.6	0.01					
Signal-peptide	IL6ST	2.0	4.7	0.00	Signal-peptide	SERPINA3	4.1	2.7	0.01					
Signal-peptide	SERPINA3	2.0	1.7	0.01	Signal-peptide	EFNB1	4.1	3.6	0.01					
Signal-peptide	IGFBP5	2.0	2.1	0.01	Signal-peptide	ABI3BP	4.1	3.5	0.01					
Signal-peptide	COL18A1	2.0	1.4	0.01	Signal-peptide	CPZ	4.4	2.0	0.01					
Signal-peptide	CST2	2.1	1.6	0.01	Signal-peptide	LYVE1	4.5	4.1	0.00					
Signal-peptide	VCAM1	2.1	3.7	0.00	Signal-peptide	EFEMP1	4.5	1.4	0.04					
Signal-peptide	TMEM130	2.2	2.5	0.00	Signal-peptide	CADM4	4.6	4.8	0.00					
Signal-peptide	CTSC	2.2	1.7	0.01	Signal-peptide	DCN	5.0	1.4	0.04					
Signal-peptide	DCN	2.4	2.0	0.01	Signal-peptide	SOD3	5.0	2.9	0.01					
Signal-peptide	SFRP4	2.4	4.1	0.00	Signal-peptide	C2	5.5	4.3	0.00					
Signal-peptide	PRG2	2.4	2.1	0.00	Signal-peptide	C1R	5.8	2.2	0.01					
Signal-peptide	CLU	2.5	3.3	0.00	Signal-peptide	IGFBP1	6.3	4.2	0.00					
Signal-peptide	EFNB1	2.5	1.7	0.01	Signal-peptide	PTGDS	7.0	3.5	0.00					
Signal-peptide	C4A	2.5	4.3	0.00	Signal-peptide	RARRES1	7.6	5.3	0.00					
Signal-peptide	A2M	2.5	1.7	0.01	Transmembrane	DPP4	3.0	2.4	0.01					
Signal-peptide	CPE	2.7	3.5	0.00	UPS	HIBADH	1.7	3.4	0.04					
Signal-peptide	PLTP	2.9	5.3	0.00	UPS	TFRC	1.7	4.2	0.02					
Signal-peptide	NBL1	3.0	1.7	0.01	UPS	SELENBP1	2.0	4.2	0.01					
Signal-peptide	CPA4	3.0	6.9	0.00	UPS	ALDH1A1	2.7	2.2	0.02					
Signal-peptide	SRGN	3.2	3.2	0.00	UPS	ANXA10	4.4	4.0	0.00					
Signal-peptide	BCAM	3.2	5.3	0.00	UPS	LXN	4.5	2.3	0.01					
Signal-peptide	PTX3	3.2	4.7	0.00										
Signal-peptide	IGFBP7	3.3	4.3	0.00										
Signal-peptide	SERPINA3	3.4	3.3	0.00										
Signal-peptide	IL6	3.4	5.5	0.00										
Signal-peptide	ABI3BP	3.5	5.5	0.00										
Signal-peptide	CHI3L2	3.5	3.4	0.00										
Signal-peptide	SOD3	4.0	3.5	0.00										
Signal-peptide	C1R	4.1	3.2	0.00										
Signal-peptide	CADM4	4.2	6.6	0.00										
Signal-peptide	LYVE1	4.3	5.6	0.00										
Signal-peptide	LIF	4.3	4.0	0.00										
Signal-peptide	SCRG1	4.3	2.9	0.00										
Signal-peptide	C2	5.1	4.1	0.00										
Signal-peptide	CPZ	5.6	4.1	0.00										
Signal-peptide	RARRES1	6.0	7.6	0.00										
Signal-peptide	IGFBP1	6.1	5.4	0.00										
Signal-peptide	PTGDS	7.5	6.0	0.00										
Transmembrane	SCARB2	1.3	2.0	0.02										
Transmembrane	ITM2B	1.7	4.1	0.00										
Transmembrane	STOM	1.7	2.3	0.01										
Transmembrane	TNFSF13B	2.3	3.1	0.00										
Transmembrane	TLL1	2.5	2.4	0.00										
Transmembrane	DPP4	3.0	3.6	0.00										
UPS	PREPL	0.9	3.2	0.04										
UPS	DDAH1	0.9	3.4	0.03										
UPS	L3HYDPH	1.0	2.2	0.04										
UPS	MIF	1.1	2.4	0.03										
UPS	GNG12	1.1	1.8	0.04										
UPS	HSPB11	1.1	2.8	0.02										
UPS	UCHL1	1.1	1.6	0.05										
UPS	AK3	1.2	2.8	0.02										
UPS	ATP5F1D	1.3	2.7	0.01										
UPS	ERH	1.4	2.3	0.02										
UPS	PIIF	1.4	3.1	0.01										
UPS	AKR1C3	1.4	3.7	0.01										
UPS	TMOD3	1.4	1.8	0.02										
UPS	ISOC1	1.5	3.7	0.01										
UPS	CCS	1.5	1.6	0.03										
UPS	GSTM3	1.5	2.4	0.01										
UPS	AKR1C2	1.5	3.7	0.01										
UPS	PDLIM5	1.5	1.9	0.02										
UPS	HIBADH	1.6	3.4	0.01										
UPS	PEA15	1.6	1.3	0.03										
UPS	HSPE1	1.6	1.8	0.02										
UPS	PRDX3	1.6	3.5	0.00										
UPS	SOD2	1.6	1.6	0.02										
UPS	HSD17B4	1.7	2.1	0.01										
UPS	S100A10	1.8	2.2	0.01										
UPS	TFRC	1.9	5.9	0.00										
UPS	PHYHD1	2.0	2.4	0.01										
UPS	HNMT	2.1	3.3	0.00										
UPS	ECH1	2.2	4.0	0.00										
UPS	ABHD10	2.3	4.0	0.00										
UPS	SELENBP1	2.4	6.6	0.00										
UPS	FBP1	2.5	3.4	0.00										
UPS	C1QB	2.6	4.6	0.00										
UPS	ALDH1A1	3.0	3.2	0.00										
UPS	ADH1C	3.0	2.3	0.00										
UPS	FABP3	3.0	6.7	0.00										
UPS	ADH1B	3.3	2.3	0.00										
UPS	QPRT	4.1	3.4	0.00										
UPS	LXN	4.6	4.1	0.00										
UPS	ANXA10	5.0	6.7	0.00										

Table S6: Correlation of DNA methylation and RNAseq data – Gene List.

Correlation of DNA methylation and RNAseq data of SE-CAFs (n = 6), and NS-CAFs (EC-CAF = 3, TE-CAF = 3) in comparison to nFBs (n = 5). Adapted from [1].

SE-CAF vs. nFB				EC-CAF vs. nFB				TER-CAF vs. nFB			
Hypermeth. / Downreg.	Hypermeth. / Upreg.	Hypometh. / Downreg.	Hypometh. / Upreg.	Hypermeth. / Downreg.	Hypermeth. / Upreg.	Hypometh. / Downreg.	Hypometh. / Upreg.	Hypermeth. / Downreg.	Hypermeth. / Upreg.	Hypometh. / Downreg.	Hypometh. / Upreg.
ADAM28	ACE2	APBB1P	A2M	ADAM28	ACE2	APBB1P	ADH1C	CTSK	CHST15	BNC1	ADH1C
ADGRE5	ADCY2	BNC1	ACSL5	ADCY7	AQP2	BNC1	APOL1	EMX2	CSGALNACT1	CCDC140	CECR2
ALX1	ALDH1L1	C10L3	ADH1C	ALDH3A1	BEGAIN	CCDC140	AQP2	FMN1	EXOC3L2	PAX3	HOXA-AS3
ANGPT1	BEGAIN	CACNA1C	AQP2	ANGPT1	CCDC3	DLEU7	ARHGAP25	HOXA11	MEOX2	PITX2	HOXA2
APCDD1L	C7	CCDC140	ARHGAP25	APCDD1L	CD244	HOXA3	AURKC	HOXB3	WNT10B	SIM1	HOXA3
BCL11B	CCDC3	DLEU7	BCL2A1	BNC1	CDH5	HOXA3	BST2	HSPB3	WT1	TFAP2B	HOXA5
BNC1	C0244	EN1	BST2	CD109	CHODL	HOXA6	C8orf4	IL31RA			OSR1
C16orf47	CDH3	GDNF	C17orf99	DMC1	CHRNA6	HOXA7	CD74	IRX1			RGS22
CCND1	CHODL	GRAMD3	C8orf4	DPT	CHST15	HOXB9	CYP11A1	NTNG1			SOST
CD109	CHRNA6	HOXA2	CD74	EMX2	COLO	MSX1	EGFLAM	PACRG			TM4SF1
CYBA	CHST15	HOXA3	CECR2	EMX2OS	CPZ	PHACTR3	F3	RCAN2			WFIKK2
DMC1	COL4A3	HOXA5	CKMT2	EXPH5	CSGALNACT1	PITX2	GRIP1	RFX8			
DPT	CYP11A1	HOXA6	CYP11A1	FAM180A	CYP26C1	PRKG2	HOXD10	RNF150			
EMX2	CRXB1	HOXA7	CYP11B1	FOX1L1	DIO3	SHOX2	HOXD3	SGIP1			
EMX2OS	CSGALNACT1	HOXB9	DLEC1	GLDN	DMD	SLC8A1	HTR2B	SLC1A2			
EXPH5	CYP26C1	IRX3	EGFLAM	HOXA10	DOCK8	STXBP6	KNDC1	TBX15			
FAM180A	DBH	KCNS3	F3	HOXA10-AS	EXOC3L2	TBX5	LAG3	TWIST1			
FMN1	DIO3	LDLRAD4	GJC2	HOXA11	FZD3	TFAP2B	LGALS3BP				
FOX1L1	EXOC3L2	MSX1	GRIPI1	HOXA9	GJC2		LINC01197				
GLDN	GJC2	PHACTR3	HOXD3	HOXB2	GRIK5		LYVE1				
GPR183	GRIK5	PITX2	HOXD9	HOXB3	GRIK5		MSC				
HOXA10	GRIK5	PRKG2	HOXC10	HOXC10	HNF4A		NR2F2				
HOXA10-AS	HOXD11	SHOX2	HOXC11	HOXC11	HPGD		NR2F2-AS1				
HOXA9	HPGD	SIM1	HOXC8	HOXC8	KRT16		NR5A1				
HOXC10	HSPB3	SLC8A1	HSD17B14	HSD17B14	LRFN1		PEAR1				
HOXC11	IGF2	STXBP6	IL20RB	IL20RB	LRFN2		RNASE1				
HOXC8	KRT19	TBX5	LINC01197	LINC01197	MEOX2		SDPR				
HOXC9	KRT9	TFAP2B	LRP1B	ITGBL1	MGAT4C		SYPL2				
HSD17B14	LRFN1	TMEM204	LYVE1	KCNK2	MITF		TCF21				
IL20RB	MITF	XDH	MSC	KIF6	MYO7A		TCF23				
IL31RA	MT1G		NR5A1	KITLG	NLGN4X		TM4SF1				
ITGBL1	MUC4		PEAR1	LAPTM5	NOS3		TRPM3				
KCNK2	MUM1L1		RGS22	LINC00801	NR5A1		TSPAN8				
KIF6	MYO7A		RNASE1	LINC01305	NUP210		VIT				
LINC00601	NR5A1		SCG5	LINC01436	PAK3		WFIKK2				
LINC00703	NUP210		SDPR	LMF1-AS1	PARM1						
LINC01305	PARM1		SIGLEC9	LNX1	PCDH11X						
LMF1-AS1	PCDH11X		TCF21	LPXN	PCYT1B						
LNX1	PKP2		TCF23	MARCO	PDLIM3						
LPXN	PRPH		TM4SF1	MASP1	PRPH						
MASP1	PTCH2		TRPM3	MCF2L	PTCH2						
MCF2L	RBP1		TSPAN8	MMP27	RBP1						
MMP27	RIMBP2		TTC12	MXRA5	SARDH						
MXRA5	SARDH		VIT	MYOM3	SCG2						
MYRIP	SCG2		WFIKK2	NBAT1	SFMBT2						
NBA11	SEMA5B			NINJ2	SCG						
NINJ2	SLC7A2			NRG1	SLPI						
NRG1	SLPI			NRG2	SOX17						
NTNG1	SOX17			NTNG1	SPOCK2						
OLFML2B	SPOCK2			OLFML2B	SSPO						
OXT	SSPO			PRRX2	STAB1						
PIWI2	STAB1			PTPN22	TRPM3						
PRRX2	TD02			RFK8	UBXN10						
PTPN22	WT1			RIPK3	UPB1						
RFK8	WT1-AS			RIPK4	WT1						
RIPK3	WWC1			RNF182	WT1-AS						
RNF112	ZMYND15			S100A4	XPNPEP2						
RNF182	ZNF608			SCN1A	ZMYND15						
S100A4				SEMA3G	ZNF608						
SCN1A				SHOX2							
SEMA3G				SLC1A3							
SHOX2				SP9							
SLC1A3				TBX15							
SP9				TCTEX1D1							
TBX15				THBS1							
TCTEX1D1				TMEM119							
THBS1				TMEM30B							
TMEM119				TMEM71							
TMEM30B				TNFRSF10C							
TMEM71				TRIL							
TNFRSF10C				TUBA1B							
TRIL				TWIST1							
TUBA1B				TWIST2							
TWIST1				ZNF788							
TWIST2											



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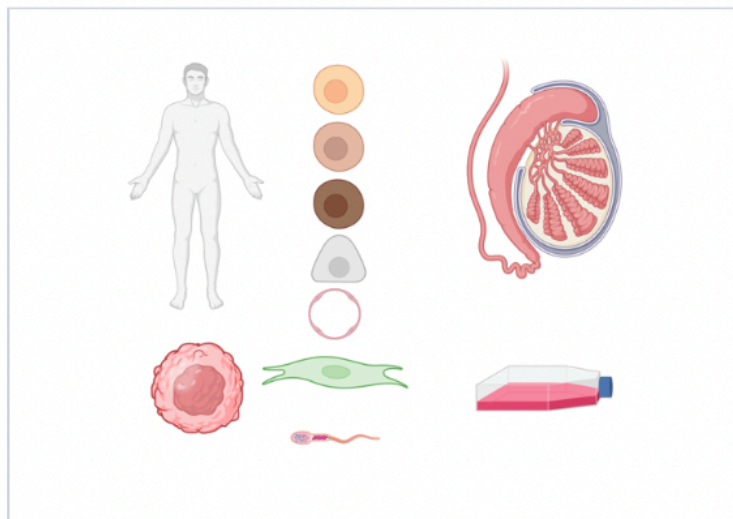
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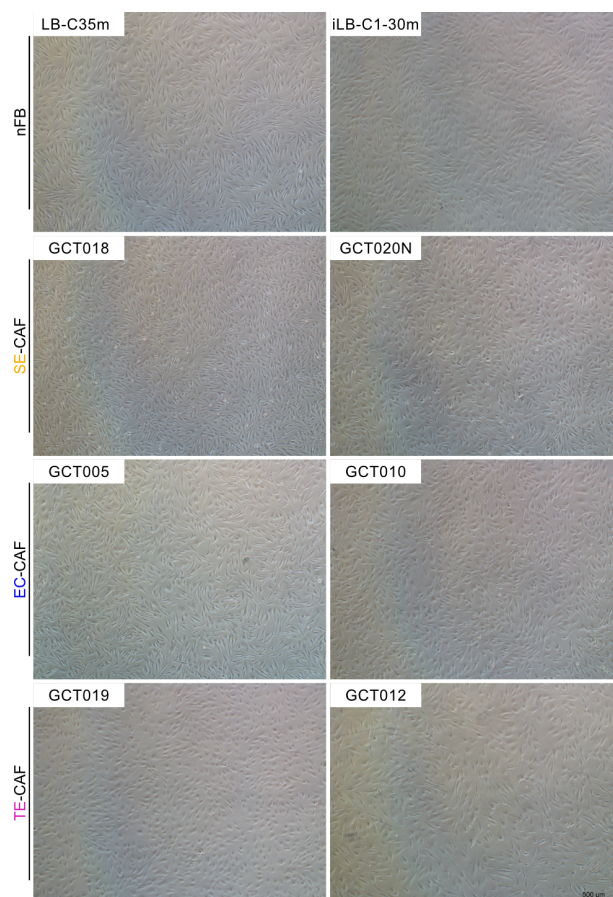


Figure S2: Raw morphology images of GCT-derived CAFs.

Uncropped and unedited (no grey filter) brightfield images of the nFB, SE-, EC-, and TE-CAF's morphology (n = 2 / subtype). Scale bar = 500 μm.

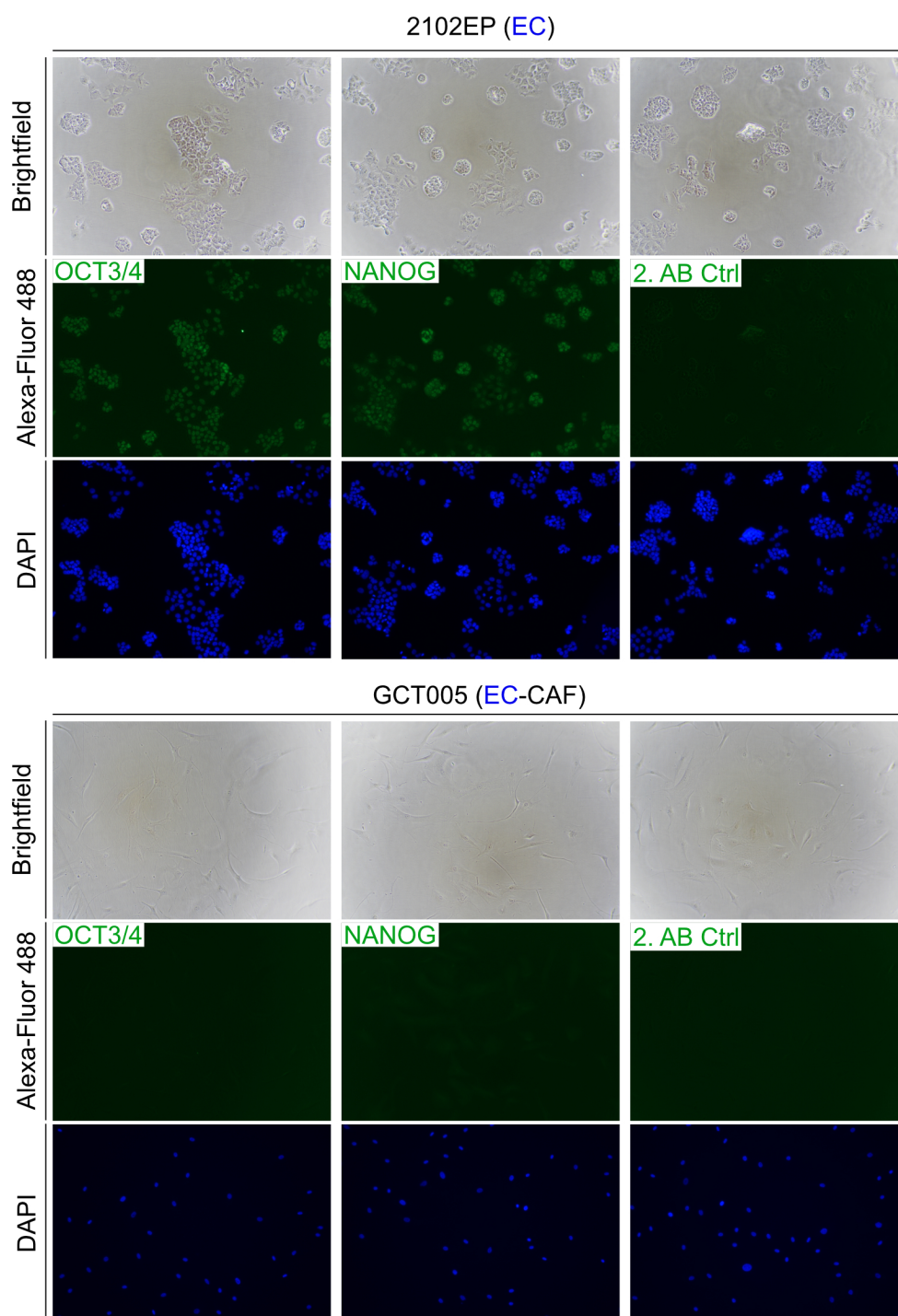


Figure S3: Raw images of immunostainings of the GCT cell line 2102EP, and EC-CAFs.

Uncropped and unaltered images of immunofluorescence stainings for OCT3 / 4 and NANOG (both green, exposure time = 1s) exemplary in one EC-CAF and in the GCT cell line 2102EP (EC) as positive control as well as brightfield pictures and secondary antibody (AB) stainings as technical control. DAPI was used as nuclear staining control (exposure time = 50 (2102EP), and = 100 ms (EC-CAF). Scale bar = 500 μ m.

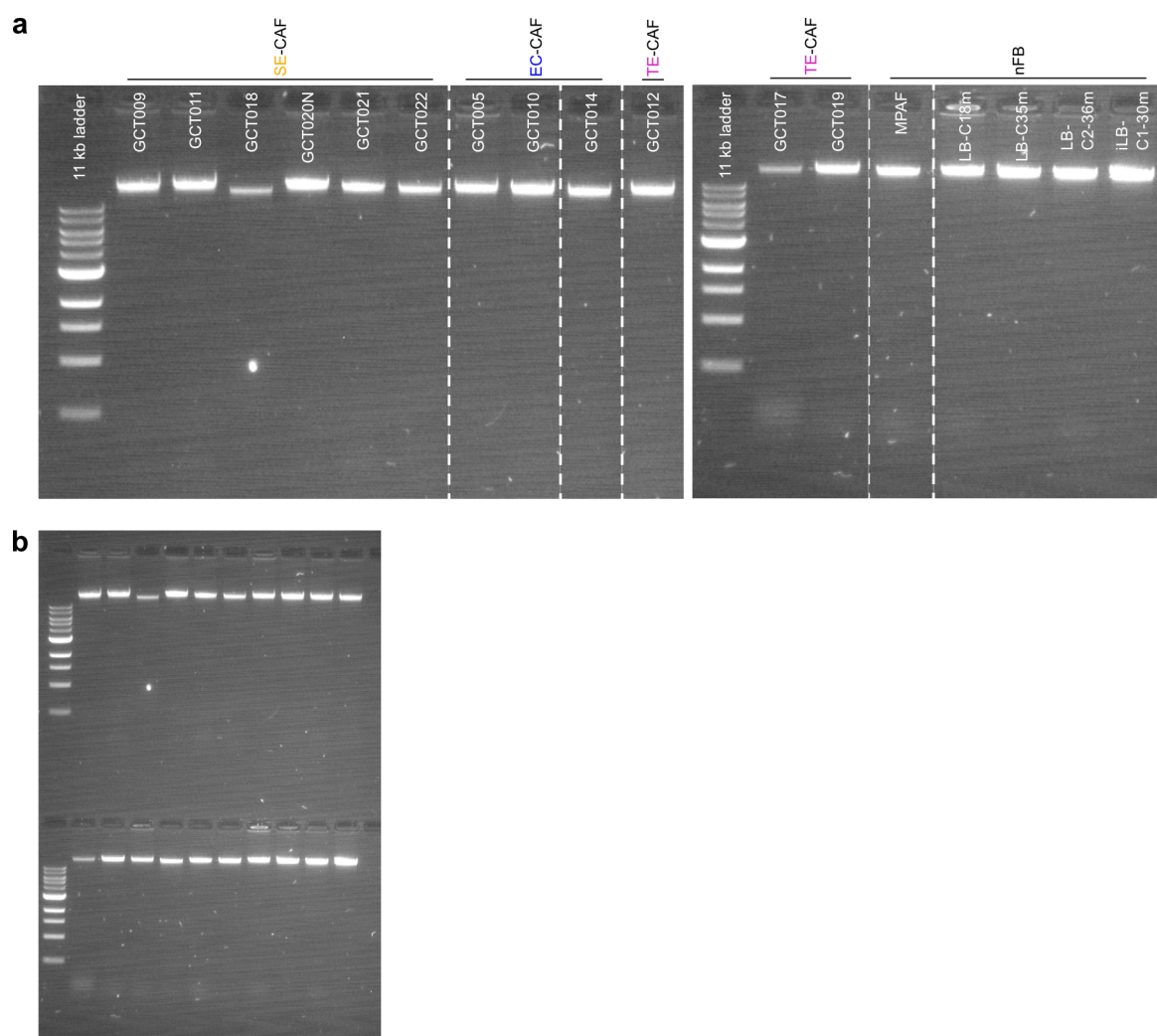


Figure S4: DNA purity confirmation for further analysis.

(a) Images of agarose gels (1.5 %) for confirmation of DNA purity (nFB = 5, SE-CAF = 6, EC-CAF = 3, TE-CAF = 3), 11 kb DNA ladder. (b) Affiliated uncropped agarose gel images.

Appendix




preQC																					
params																					
Chem ID's											4823.										
sample type											Total RNA										
photometric assay											RNA - factor 40										
photometric device											NanoDrop 8000 (GTL-069)										
dilution buffer											water										
integrity assay											FA DNF - 471 (RNA Kit)										
integrity device											Fragment Analyzer 5300 (GTL-289)										
fluorometric assay DNA																					
fluorometric assay RNA											Qubit RNA HS										
fluorometric device											Qubit Flex (GTL-303)										
preQC qPCR Assay																					
qPCR device																					
comment																					
#	sample id	derivatID (chid)	well	plate name	photo metric conc. (ng µl)	260_280	260_230	dilution factor	dilution volume (µl)	IntegrityQC Value(DIN, RIN,RQN)	mean fragment size (bp)	fluorometri c conc. DNA (ng µl)	fluorometri s conc. RNA (ng µl)	qPCR conc. (ng µl)	perc. amplifiable amount	cell conc. (cells/µl)	cell vitality (%)	QC score	qualitative Freigabe	location	freeze
1	GCT009				114.50	2.07	2.03	1.6	13.10	10.00			60.60					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
2	GCT011				114.50	2.05	2.03	1.6	13.10	9.70			61.20					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
3	GCT018				107.60	2.01	1.91	1.5	12.30	10.00			61.50					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
4	GCT020				211.90	2.01	2.22	3.0	24.20	10.00			31.40					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
5	GCT021				83.37	1.98	1.73	1.2	9.50	10.00			68.60					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
6	GCT022				96.09	1.95	1.71	1.4	11.00	10.00			60.00					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
7	GCT005				119.20	1.98	2.14	1.7	13.60	10.00			65.40					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
8	GCT010				95.32	2.04	1.95	1.4	10.90	10.00			60.80					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
9	GCT012				110.90	2.05	1.80	1.6	12.70	10.00			63.30					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
10	GCT014				112.80	2.04	2.07	1.6	12.90	10.00			57.90					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
11	GCT017				104.70	2.02	2.09	1.5	12.00	10.00			65.80					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
12	GCT019				86.42	2.08	1.85	1.2	9.90	10.00			78.90					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
15	MPAF				94.59	2.02	1.87	1.4	10.80	10.00			66.30					1	yes	Kombi-KS-	TW/16.09.2022
17	LB-C18m				99.16	2.01	1.53	1.4	11.30	10.00			60.70					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
18	LB-C35m				106.10	2.07	2.04	1.5	12.10	10.00			60.00					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
19	LB-C2-36m				103.30	2.01	2.09	1.5	11.80	10.00			68.40					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
20	LB-C1-30m				99.79	2.03	1.89	1.4	11.40	10.00			68.10					1	yes	Kombi-KS-GS-R61-G TL-102	TW/16.09.2022
QC SCORE																					
1  passed: sample quality is suitable for desired application						2  conditional pass: sample quality is most likely suitable for desired application						3  not passed: sample quality is not suitable for desired application									

Figure S5: RNA quality validation for RNAseq.

Quality control by 'Genomics and Transcriptomics Laboratory' of the BMFZ at the HHU. Integrity number marked in red. Integrity number >9 = suitable for RNAseq.

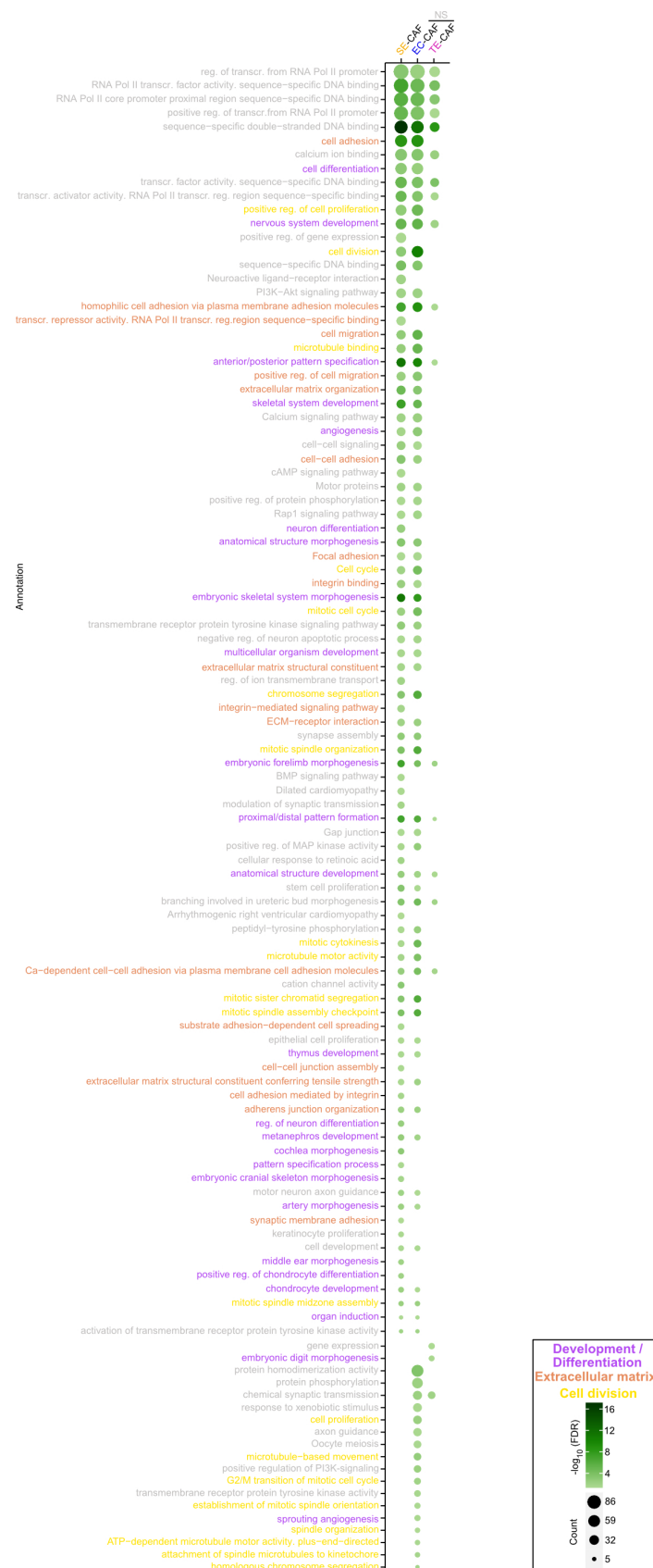


Figure S6: Annotation analysis of downregulated genes.

Gene annotation analysis via DAVID.com of downregulated genes ($\log_{2}\text{FC} < -2$, $\text{FDR} < 0.05$) in SE-CAF ($n = 6$) and NS-CAF (EC-CAF ($n = 3$), and TE-CAF ($n = 3$)) compared to nFB ($n = 5$). Annotations summarized as groups: developmental / differentiation processes (purple), ECM remodeling (orange), cell division (yellow). Shade of green indicating the P ($-\log_{10}(\text{FDR})$) and circle size reflecting the number of genes related to the annotation. Reg.: regulation, transcr.: transcription

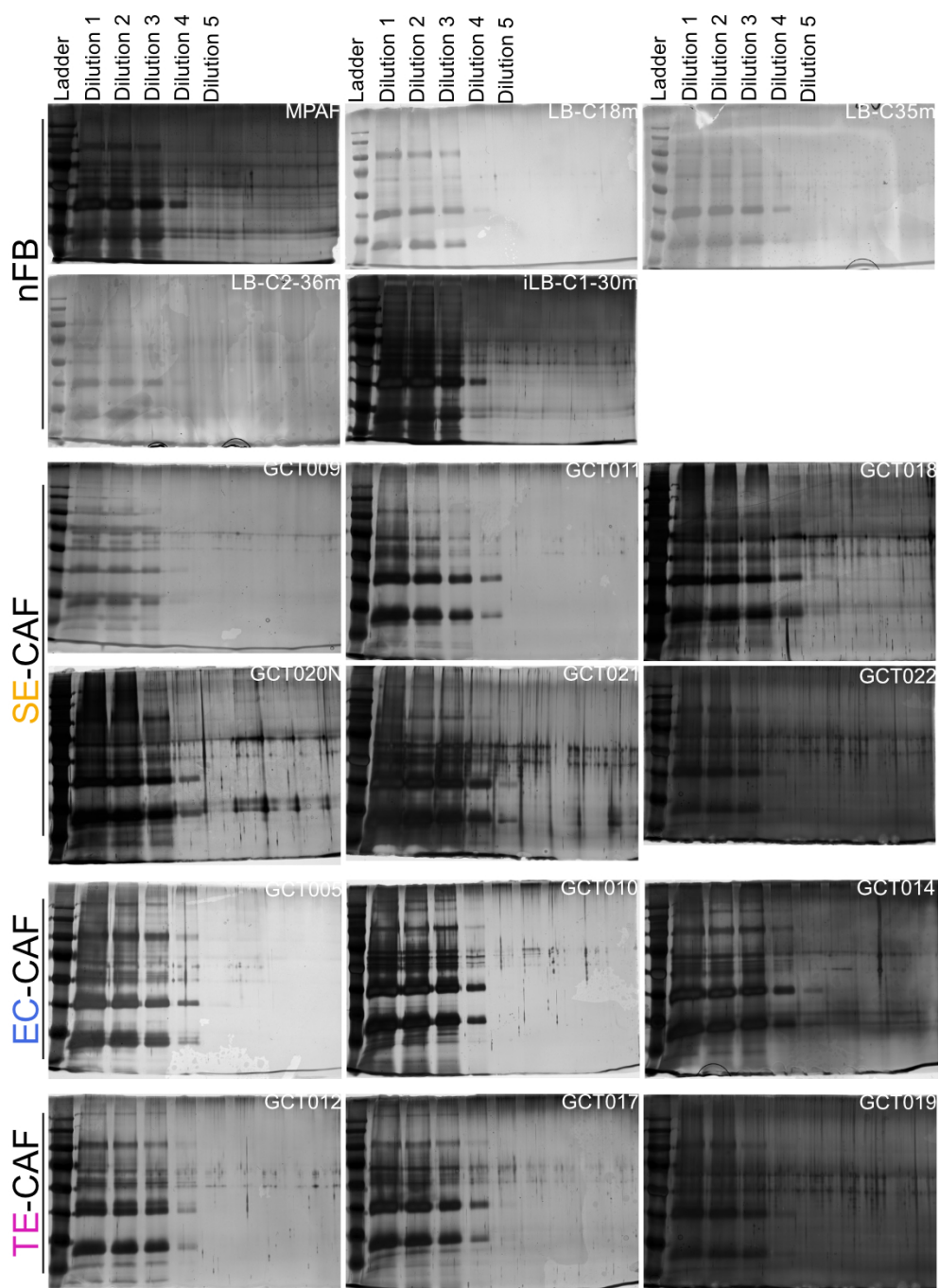


Figure S7: Raw images of silver stainings for supernatant validation.

Silver gels with dilutions (15 μ L, 10 μ L, 5 μ L, 1 μ L, 0.1 μ L) of TCA precipitated proteins of GCT-CAF (SE-CAF: n = 6; NS-CAF (EC-CAF: n = 3, TE-CAF: n = 3)) and nFB (n = 5) supernatants in 10 % PA-gels, with 250 kDa protein ladder.

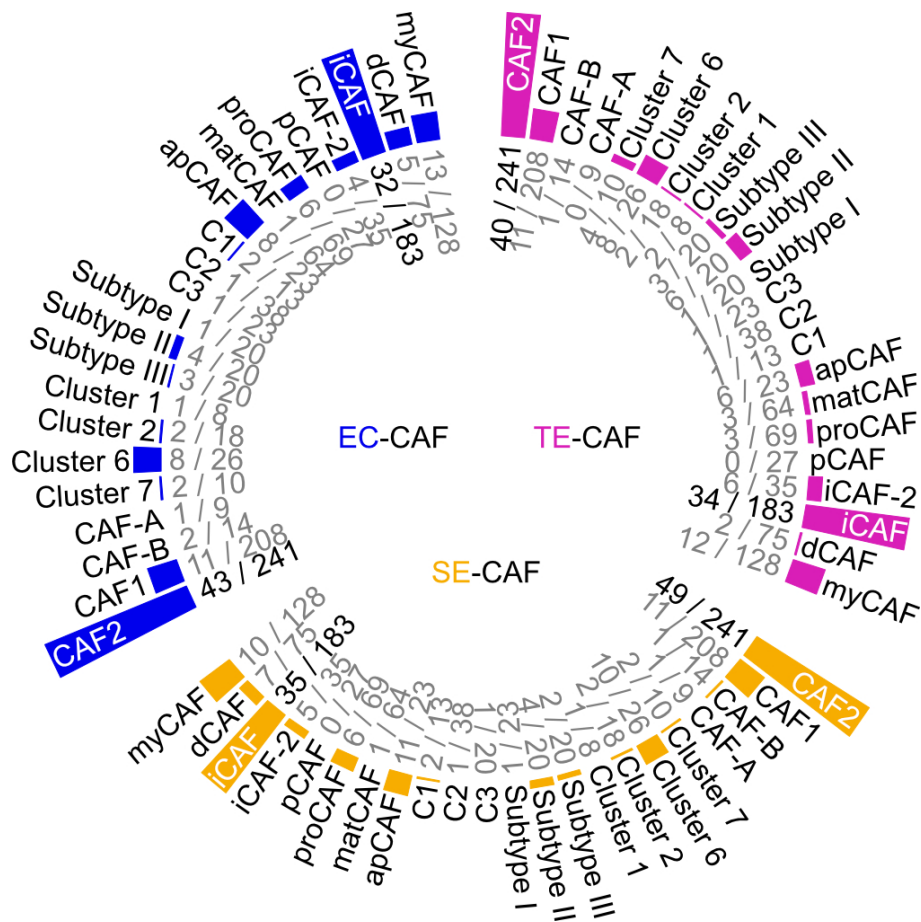


Figure S8: GCT-CAF phenotyping.

Phenotyping of GCT-CAF by comparing their gene expression of commonly known marker of different CAF phenotypes with our RNAseq data. Inner circle indicating the number of upregulated genes found in SE-, EC-, and TE-CAF out of the total number of genes of specific CAF phenotype marker set. C1 = Non-DDR-C1, C2 = CDK4+CAF-C2, C3 = NSMCE4A+CAF-C3. Adapted from [1].

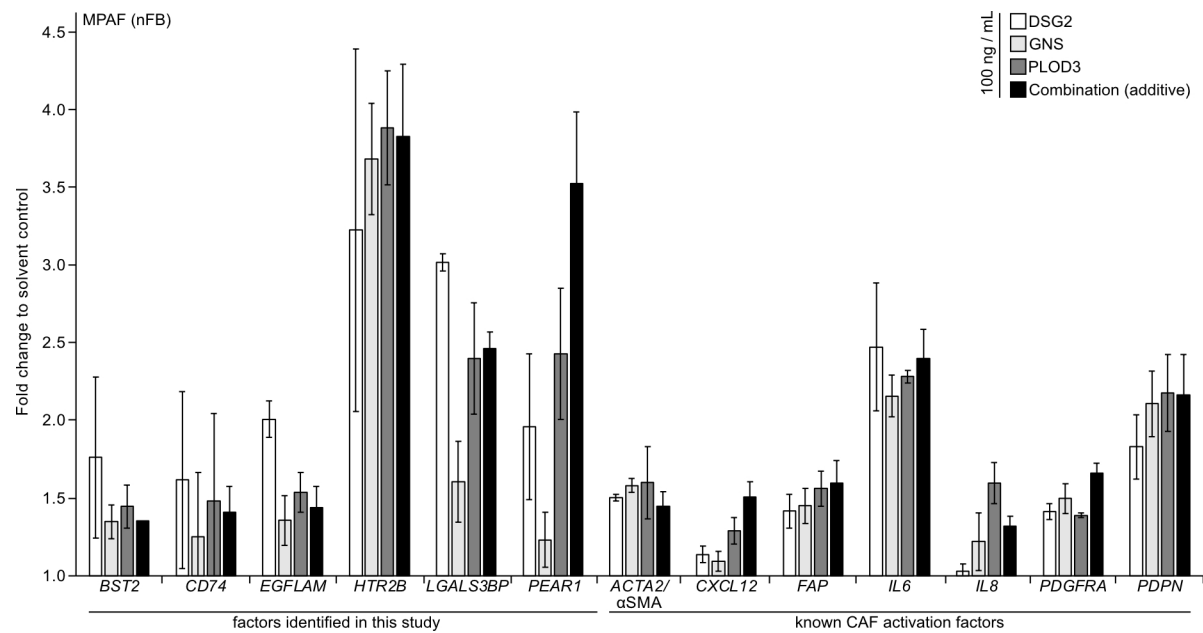


Figure S9: *In vitro* activation of nFB by the GCT secreted factors DSG2, GNS, and PLOD3.

qRT-PCR analysis of common CAF activation markers and GCT-CAF markers identified in this study in daily treated MPAF (nFB) with 100 ng / mL recombinant protein DSG2, GNS, or PLOD3 or in a triple combination over 120 h. SD is based on technical triplicates. *GAPDH* and *ACTB* were used as housekeepers and data normalization. Adapted from [1].

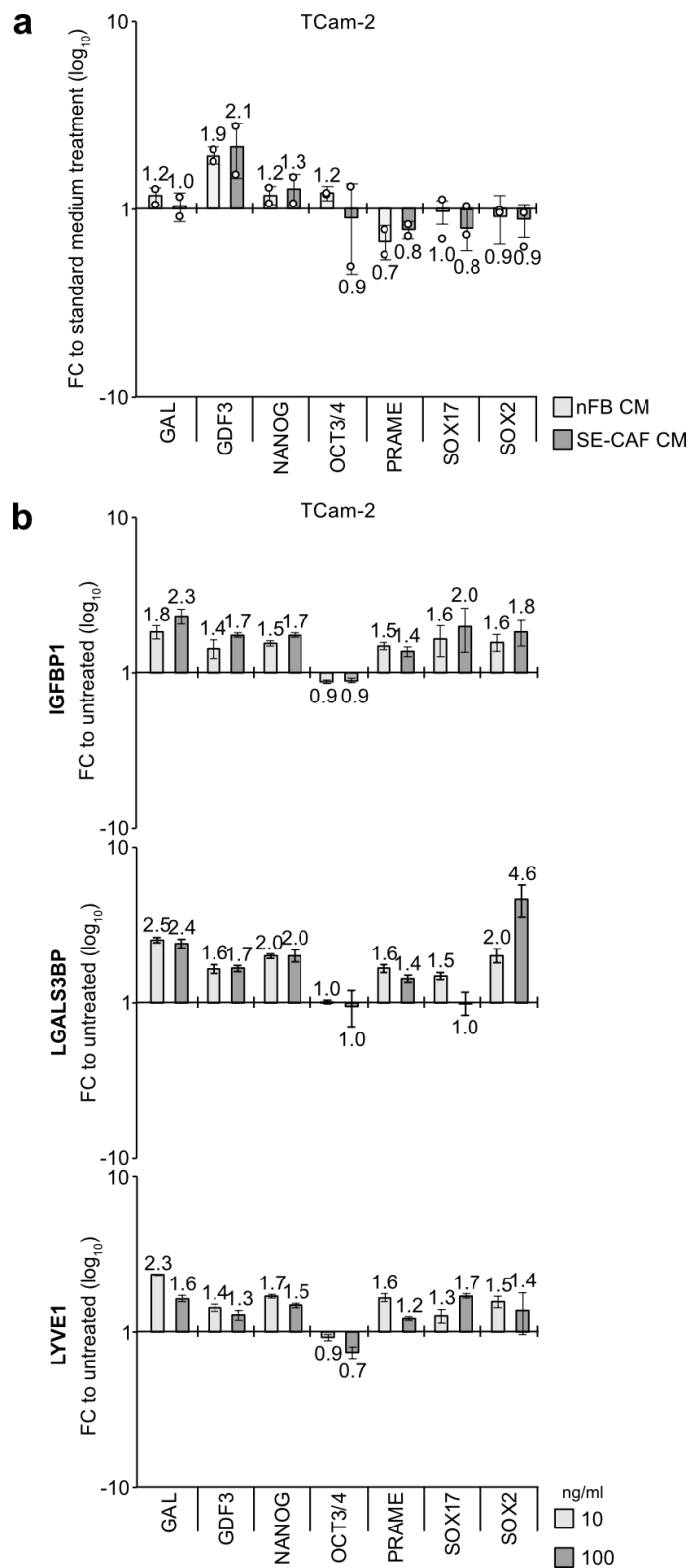


Figure S10: Influence of GCT-CAF on pluripotency status of TCam-2.

qRT-PCR analysis of *GAL*, *GDF3*, *NANOG*, *POU5F1/OCT3/4*, *PRAME*, *SOX17*, and *SOX2* expression in TCam-2 (a) treated daily with CM of two nFB or two SE-CAF over 10 days. (SD of all 6 technical replicates), or (b) treated daily with 10 or 100 ng / ml of IGFBP1, LGALS3BP or LYVE1 and analyzed after 10 d (SD based on technical triplicates).

Contribution

Das Grundkonzept des Promotionsprojektes wurde durch Daniel Nettersheim erstellt. Die Finanzierung wurde von der Wilhelm-Sander-Stiftung gewährleistet (2020.104.1, 2022.123.1). Alexa Stephan war für die generelle experimentelle Planung und Durchführung verantwortlich.

Für die Operation bzw. Bereitstellung der Patientenproben und generelle Koordination innerhalb der urologischen Klinik waren Dr. med. Yue Che und Dr. med. Pailin Pongratanakul verantwortlich. Patienteninformationen (Alter, Staging, Klassifizierung und Subtype) wurden von Dr. Pailin Pongratanakul zur Verfügung gestellt und von Alexa Stephan aufbereitet. Kommunikation zwischen urologischer Klinik und urologischem Forschungslabor wurde von Ph.D Margaretha Skowron und Alexa Stephan koordiniert und die Proben durch Alexa Stephan aufbereitet. Alle Patientenproben für die Hochdurchsatzverfahren wurden von Alexa Stephan vorbereitet. Die Hochdurchsatzmethoden und deren Software-gekoppelten und formalen statistischen Grundausswertungen wurden von externen Kooperationspartner/innen durchgeführt (DNA-Methylierung: Dr. med. Catena Kresbach und Prof. Dr. Ulrich Schüller (*Institut für Neuropathologie*, Universitätsklinikum Hamburg-Eppendorf, Hamburg, Deutschland); RNA-Sequenzierung: Dr. rer. nat. Patrick Petzsch und Prof. Dr. Karl Köhrer (Genomics & Transcriptomics Laboratory); Massenspektrometrie: Dr. rer. nat. Gereon Poschmann und Prof. Dr. Kai Stühler (Molecular Proteomics Laboratory)). RNA Qualität wurde ebenfalls extern bei dem Genomics & Transcriptomics Laboratory festgestellt. Koordination mit den externen Kooperationspartnern wurde durch Alexa Stephan geleitet. Statistische formale Grundausswertung der DNA-Methylierung wurde von Dr. rer. nat. Wasco Wruck und Prof. Dr. James Adjaye (*Institut für Stammzellforschung und regenerative Medizin*) übernommen.

Alle weiteren Methoden und Analysen (Kultivierung der CAF-Kulturen, qRT-PCR, SDS-PAGE, Silberfärbung, ELISA, Immunofluoreszenzfärbungen, Proliferationsassays) wurden von Alexa Stephan durchgeführt. (Statistische) Auswertungen dieser Analysen (qRT-PCR, ELISA, Proliferationsassays) wurden von Alexa Stephan durchgeführt. Alle weiteren Auswertungen zur biologischen Relevanz (Online Tools: DAVID, STRING, TIMER2.0) und Illustrationen (schematische Darstellungen, Diagramme, Tabellen, Volcano / Violin plots, Principal component analysis) wurden nach vorheriger Anleitung und Bereitstellung einiger Skripte (Volcano / Violin plots, Principal component analysis) von Ph.D Margaretha Skowron eigenständig von Alexa Stephan erstellt und graphisch angepasst. Einzige Ausnahme stellt die Heatmap der RNA-Sequenzierung dar, die von Dr. Patrick Petzsch zur Verfügung gestellt worden ist. Das Manuskript der zugehörigen Publikation wurde von Alexa Stephan und Daniel Nettersheim geschrieben. Der größte Gesamtanteil der Publikation wurde von Alexa Stephan geleistet.

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Liebste Anna, du im Urlaub. Ich die erste Woche Postdocin. Chaos. Explosionen. Ein greller Blitz am Himmel. Stromausfall. Nein zum Glück nicht, denn für alles gibt es Ordner und Listen und Protokolle und Fächer und Vorgaben und Zettel. Wo kannst du eigentlich keine Ordnung reinbringen? Ich hoffe du weißt, dass du maßgeblich daran beteiligt bist, dass hier alles so gut läuft. Auch dich habe ich noch nie gestresst erlebt (außer Freitag nachmittags nach 17 Uhr in der Zellkultur im alten Gebäude) und du wusstest auf alles eine Antwort.

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Das Schlusswort dieser Dissertation muss an eine bestimmte Person gerichtet werden, ohne die ich hier heute so nicht stände. Die Weltenwanderin hat es geschafft, danke.