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Common breast cancer susceptibility loci are associated with triple negative breast cancer

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Abstract

Triple negative breast cancers are an aggressive subtype of breast cancer with poor survival, but there remains little known about the etiological factors which promote its initiation and development. Commonly inherited breast cancer risk factors identified through genome wide association studies (GWAS) display heterogeneity of effect among breast cancer subtypes as defined by estrogen receptor (ER) and progesterone receptor (PR) status. In the Triple Negative Breast Cancer Consortium (TNBCC), 22 common breast cancer susceptibility variants were investigated in 2,980 Caucasian women with triple negative breast cancer and 4,978 healthy controls. We identified six single nucleotide polymorphisms (SNPs) significantly associated with risk of triple negative breast cancer, including rs2046210 (ESR1), rs12662670 (ESR1), rs3803662 (TOX3), rs999737 (RAD51L1), rs8170 (19p13.11) and rs8100241 (19p13.11). Together, our results provide convincing evidence of genetic susceptibility for triple negative breast cancer.

Keywords

genetic susceptibility; neoplasms; association study; subtypes; common variant

Introduction

Triple negative (TN) breast cancers are a biologically and clinically distinct subtype of breast cancer, defined as tumors that exhibit low or no expression of estrogen receptor (ER), progesterone receptor (PR), and human epidermal growth factor receptor-2 (HER2) (1). Women with TN disease account for approximately 15% of all invasive breast cancers and are more likely to be younger, African American, have an earlier age at menarche, higher body mass index during premenopausal years, higher parity, and a lower lifetime duration of breast feeding (2-4). In addition, TN tumors are typically of higher histologic grade and are associated with more aggressive disease and poorer survival (1, 5, 6). These differences in tumor pathology, non-genetic risk factors, and survival among women with TN disease suggest that the etiology of these tumors may differ from other breast cancer subtypes.

Genome wide association studies (GWAS) have recently identified common, low-penetrance susceptibility variants that are associated with risk of breast cancer (7-16). Growing evidence suggests substantial heterogeneity by tumor subtype, defined by hormone receptor status, for associations with these SNPs. In particular, variants in 5p12, *FGFR2*, 8q24, 1p11.2, 9p21.3, 10q21.2, and 11q13 are associated with risk of developing ER-positive tumors (9-12, 14, 17, 18) but not ER-negative tumors, whereas variants in 2q35, *TOX3*, *LSP1*, *MAP3K1 TGFB1* and *RAD51L1* are associated with both ER-positive and ER-negative disease (19). To date, no variants have been specifically associated with ER-negative or TN disease. However, variants at *TOX3*, 2q35, and two distinct signals at 19p13.1 have been associated with breast cancer risk in *BRCA1* mutation carriers, who predominantly develop tumors displaying an ER-negative and TN phenotype (15, 20, 21). Thus, additional studies specifically investigating ER-negative and TN disease are necessary to understand genetic susceptibility to these breast cancer subtypes.

Here we report on the first TNBCC study of genetic susceptibility to TN breast cancer in which associations between 22 common breast cancer susceptibility loci and risk among 2,980 cases and 4,978 controls were evaluated. This comprehensive study included 21 common variants from all known susceptibility loci identified through currently published breast cancer GWAS (1p11.2, 2q35, 3p24/*NEK10*, 5p12/*MRPS30*, *MAP3K1*, *ESR1*, 8q24, 9p21.3, 9q31.2, 10p15.1, 10q21.2/*ZNF365*, 10q22.3/*ZMIZ1*, *FGFR2*, *LSP1*, 11q13, *RAD51L1*, *TOX3*, 17q23/*COX11*, 19p13.1) and a SNP from *CASP8* identified in a

candidate-gene study of *CASP8* (22, 23). We show that SNPs from four of these loci are strongly associated with risk of TN breast cancer.

Materials and Methods

Ethics Statement

Study subjects were recruited on protocols approved by the Institutional Review Boards at each participating institution, and all subjects provided written informed consent.

Study populations

Samples from several TN breast cancer case-control series, including 2,778 TN breast cancer cases and 1,406 unaffected controls, were genotyped on the iPLEX platform. These subjects were ascertained by 22 studies in 10 different countries: United States, Australia, Great Britain, Finland, Germany, Netherlands, Greece, Ireland, and Sweden. These included cases from the KBCP and POSH cohort studies, cases and controls from the MCCS cohort study, and cases and controls from established population-based breast cancer case-control studies (BBCS, GENICA, MARIE, SEARCH), hospital or clinic based case-control studies (ABCS, BIGGS, LMBC, MCBCS, OBCS, SBCS, and RPCI), case-only studies with geographically matched controls (BBCC, KARBAC, SKKDKFZS, FCCC), and unselected cases identified in tumor collections (DFCI, ABCTB, DEMOKRITOS). Data from an ongoing GWAS of TN breast cancer, including cases and controls from several of the studies described above, and the TN cases from the HEBCS GWAS along with population control data (n=273) were also included (24). In addition, data from four publicly available control GWAS data sets (Wellcome Trust Case Control Consortium UK 1958 Birth Cohort (WTCCC), National Cancer Institute's Cancer Genetic Markers of Susceptibility (CGEMS) project, Cooperative Health Research in the Region of Augsburg (KORA) study, and the Australian Twin Cohort study from the Queensland Institute of Medical Research (QIMR)) (n=3,593) were utilized. Age distributions and years of diagnosis for individual study sites are provided in **Supplementary Table 1**, and these studies are described in more detail in Supplementary Material.

Pathology and tumor markers

A TN breast cancer case was defined as an individual with an ER–negative, PR–negative and HER2–negative (0 or 1 by immunohistochemical staining (IHC)) breast cancer diagnosed after age 18. Criteria used for defining ER, PR, and HER2 status varied by study. These are described in detail in **Supplementary Table 2**. CK5/6 and EGFR IHC data for identification of basal tumors were not available.

Genotyping

The following 22 SNPs were genotyped on the iPLEX platform: rs11249433 (1p11.2), rs13387042 (2q35), rs4973768 (3p24), rs10941679 (5p12), rs889312 (*MAP3K1*), rs2046210 (*ESR1*), rs12662670 (*ESR1*, surrogate for rs9397435), rs13281615 (8q24), rs1011970 (9p21.3), rs865686 (9q31.2), rs2380205 (10p15.1), rs10509168 (10q21.2, surrogate for rs10995190), rs704010 (10q21.2), rs2981582 (*FGFR2*), rs3817198 (*LSP1*), rs614367 (11q13), rs999737 (*RAD51L1*), rs3803662 (*TOX3*), rs6504950 (17q23), rs8170 (19p13.11), rs8100241 (19p13.11), and rs17468277 (tagSNP for *CASP8* D302H). For 10q21.2, rs10509168 was genotyped as a surrogate for rs10995190 (14).

Genotype data for 22 SNPs were generated for 2,778 cases and 1,406 controls using a single multiplex on the iPLEX Mass Array platform (Sequenom). Samples were plated by study as random mixtures of cases and controls with no-template and CEPH controls in every plate. Genotyping quality for SNPs and samples was evaluated using an iterative quality control

(QC) process. SNPs and samples were excluded based on the following criteria: SNP call rate <95%, Hardy-Weinberg equilibrium (HWE) p-value <0.01 among controls, and sample call rate <95%. The final dataset of 2707 cases and 1385 controls exhibited SNP call rates >99%, HWE p-value >0.01, and sample call rates >95%.

In addition, genotype data from cases and controls included in a TN GWAS were available to supplement the iPLEX genotypes. Cases from 10 study sites (ABCTB, BBCC, DFCI, FCCC, GENICA, MARIE, MCBCS, MCCS, POSH, SBCS) were genotyped using the Illumina 660-Quad SNP array. A subset of MARIE cases were genotyped using the Illumina CNV370 SNP array. HEBCS cases and controls were genotyped using the Illumina 550-Duo SNP array. GWAS data for public controls were generated using the following arrays: Illumina 660-Quad (QIMR), Illumina 550(v1) (CGEMS), Illumina 550 (KORA), and Illumina 1.2M (WTCCC). For HEBCS, population allele and genotype frequencies on 221 healthy population controls genotyped on Illumina HumanHap 370CNV in the NordicDB, a Nordic pool and portal for genome-wide control data, were obtained from the Finnish Genome Center (25). These GWAS data were independently evaluated by an iterative QC process with the following exclusion criteria: minor allele frequency (MAF) <0.01, call rate <95%, HWE p-value $<1\times10^{-7}$ among controls and sample call rate <98%. When DNA was available (n=1,402), we re-genotyped samples from the TN GWAS as part of the iPLEX study in an effort to obtain as much data as possible from a single platform. Therefore, following preferential selection of data from the iPLEX study, genotypes for an additional 273 cases and 3,593 controls were included from the GWAS data (**Table 1**). No GWAS genotype data were available for rs10941679 (5p12), rs2046210 (*ESR1*), rs6504950 (17q23) and only partial data were available for five other SNPs because of the absence of these SNPs from some or all of the GWAS genotyping platforms (**Table 1**). As a further measure of genotype quality, genotype concordance was evaluated for the 1,402 samples included in both the iPLEX and GWAS. Eighteen of 19 SNPs, had concordance rates >98% and rs8100241 showed concordance of 96.3% .

Statistical methods

Allele frequencies for each of the 22 SNPs included in these analyses were estimated using the iPLEX genotype data and the combined GWAS and iPLEX data for cases, controls, and all subjects (**Supplementary Table 3**). Associations for TN breast cancer were estimated using unconditional logistic regression adjusted for country of residence. The sites were categorized by country of origin (American, Australian, British, Finnish, German, Greek, Irish, and Swedish) (**Table 1**). SNPs were coded for a gene-dose effect by assigning a three-level (0, 1, 2) variable to each genotype (log-additive model). We calculated p-values, odds ratios (ORs) and 95% confidence intervals from these logistic regressions. Pair-wise interactions were tested by including multiplicative interaction terms in logistic regression models. Homogeneity of ORs by country was tested using the Q statistic (26) and the extent of heterogeneity was estimated by the I^2 statistic (27). All analyses were conducted using SAS version 9.2, R version 2.11.0, or Plink version 1.07.

Results

We evaluated 22 breast cancer susceptibility SNPs identified in breast cancer GWAS for associations with TN disease using genotype data from an iPLEX study of the 22 SNPs supplemented with data from a TN GWAS. The combined data resulted in a case-control study of 2,980 cases and 4,978 controls from 25 studies in eight countries (**Table 1**). All 22 SNPs were in Hardy-Weinberg equilibrium among controls at p>0.01. Only rs17468277 and rs1011970 showed evidence of heterogeneity by country (rs17468277: p=0.047, I^2=50.8%; rs1011970: p=0.093, I^2=42.8%). Of the 22 SNPs from 20 loci, eight were significantly associated with risk of TN breast cancer (p<0.05) (**Table 2**). Six SNPs from four loci,

rs2046210 ($p=4.38 \times 10^{-7}$), rs12662670 ($p=1.13 \times 10^{-4}$), rs999737 ($p=2.96 \times 10^{-4}$), rs3803662 ($p=3.66 \times 10^{-5}$), rs8170 ($p=2.25 \times 10^{-8}$), and rs8100241 ($p=8.66 \times 10^{-7}$), remained significant after correction for multiple testing ($p<2.27 \times 10^{-3}$). Adjustment for age did not change the magnitude or significance of our results. In addition, we did not find evidence of significant interactions with age for any of the 22 SNPs.

Rs2046210, located upstream of *ESR1* on chromosome 6q25.1, exhibited a strong association with TN disease [odds ratio (OR)=1.29, 95% Confidence Interval (CI) 1.17 – 1.42; $p=4.38 \times 10^{-7}$] (**Figure 1a**), whereas rs12662670, located further upstream of *ESR1*, displayed a similar effect but slightly less significant association with TN disease [OR=1.33-fold, 95% CI 1.15 – 1.53; $p=1.13 \times 10^{-4}$] (**Figure 1 b**). To assess the independence of these two *ESR1* SNPs, which are not correlated in HapMap subjects of European ancestry ($r^2=0.09$), we included both SNPs in a multivariate model. Rs2046210 was more strongly associated with TN risk than rs12662670 [rs2046210 OR=1.24, 95% CI 1.12 – 1.38; $p=5.64 \times 10^{-5}$; rs12662670 OR=1.20, 95% CI 1.00 – 1.44; p=0.053] in this model, suggesting that rs2046210 may account in part for these two associations. In addition, two SNPs at 19p13.1 shown to have genome wide significant associations with breast cancer in *BRCA1* mutation carriers, were highly significantly associated with TN breast cancer [rs8170: OR=1.27, 95% CI 1.17 – 1.38; $p=2.25 \times 10^{-8}$] [rs8100241: OR=0.84, 95% CI 0.78 – 0.90; $p=8.66 \times 10^{-7}$] (**Figure 1 c,d**). Multivariate modeling of these two SNPs, which are moderately correlated in HapMap subjects of European ancestry ($r^2=0.74$), showed that rs8170 is more strongly associated with TN breast cancer risk [rs8170: OR=1.22, 95% CI 1.10 – 1.34; $p=7.56 \times 10^{-5}$; rs8100241: OR=0.90, 95% CI 0.83 – 0.98; p=0.014] although both variants are retained in the model. Additionally, rs3803662 (*TOX3*), which has been strongly associated with risk of ER-negative breast cancer (OR=1.15, $p=2.1 \times 10^{-10}$) (19), was associated with a 1.17-fold increase in risk of TN disease [OR=1.17, 95% CI 1.09 – 1.26; $p=3.66 \times 10^{-5}$] (**Figure 1e**). Likewise, the rs999737 (*RAD51L1*) SNP was significantly associated with risk of TN breast cancer [rs999737 OR=0.86, 95% CI 0.80 – 0.93; $p=2.96 \times 10^{-4}$] (**Figure 1f**). In contrast, rs17468277 (*ALS2CR12/CASP8*) (p=0.005) was not significantly associated with TN breast cancer risk after correction for multiple testing, suggesting that this result should be interpreted with caution. None of these six SNPs showed evidence of heterogeneity by country (**Figure 1**). To further understand the influence of variants in the 6q25.1 and 19p13.11 loci on TN risk, we looked for statistical interactions between the SNPs in these regions. While there was no evidence for a statistical interaction between rs2046210 and rs1266270 (p=0.820) at 6q25.1, we found strong evidence of an interaction (p=0.004) between rs8170 and rs8100241 from 19p13.1, in a multiplicative model.

Next we performed a subset analysis using the iPLEX data alone (2,707 cases, 1,385 controls) for the 19 SNPs with both iPLEX and GWAS genotypes to assess the consistency of our results. Analysis of associations with TN disease in the iPLEX-only dataset showed that odds ratios for the 19 SNPs were consistent in both direction and magnitude of effect compared to the analysis using all available genotype data, although some variation in the significance of the associations was observed (**Table 2**). Four of the SNPs significantly associated with TN breast cancer in the overall analysis retained statistical significance in the iPLEX-only analysis (rs12662670 $p=3.52 \times 10^{-4}$; rs3803662 $p=8.25 \times 10^{-4}$; rs8170 $p=7.30 \times 10^{-8}$; rs8100241 $p=1.81 \times 10^{-6}$) after correction for multiple testing. Results were unchanged for rs2046210 from the *ESR1* locus, because the overall analysis was restricted to iPLEX data as a result of missing GWAS data for this variant. Finally, while the rs999737 (*RAD51L1*) SNP was only marginally associated with TN breast cancer risk in the iPLEX-only analysis (rs999737 p=0.053), the estimate of effect for this SNP was consistent with the effect observed in the overall analysis.

Importantly, genotype data from a subset of these cases and controls have previously been used in association studies involving a number of these SNPs by the Breast Cancer Association Consortium (BCAC). To avoid duplication and to assess the degree to which these BCAC samples influenced our results, we also performed a subset analysis in which we excluded all cases and controls used in the BCAC studies (n=1,819 cases; n=4,038 controls) (**Supplementary Table 4**). The effect estimates and significance of associations with TN disease in either the iPLEX or combined analyses were not substantially modified following the removal of these cases and controls (**Supplementary Table 5**).

Discussion

Here we report on the first study by the TNBCC and the largest study to date of genetic susceptibility to TN breast cancer, which is comprised 2,980 cases and 4,978 controls from 25 studies in eight countries. We show that a subset of breast cancer susceptibility SNPs identified through GWAS are also associated with risk of TN breast cancer. Specifically, we determined that six breast cancer susceptibility SNPs from four loci- rs2046210 (*ESR1*), rs12662670 (*ESR1*), rs999737 (*RAD51L1*), rs3803662 (*TOX3*), rs8170 (19p13.1) and rs8100241 (19p13.1)- are associated with risk of TN breast cancer. Of these, rs8170 (19p13.1) achieved genome-wide significance ($p=2.25 \times 10^{-8}$). Overall, these findings provide strong evidence of genetic susceptibility to triple negative breast cancer.

We identified highly significant associations between SNPs at 6q25.1 and risk of TN breast cancer, including rs12662670 ($p=1.13 \times 10^{-4}$) and rs2046210, which reached near genome-wide significance ($p=4.38 \times 10^{-7}$). These variants are located approximately 30kb and 60kb upstream of the first untranslated exon and 180kb and 210kb upstream of the first coding exon of *ESR1*, which encodes the estrogen receptor-α protein.

The rs2046210 SNP was originally reported in a breast cancer GWAS in Chinese women (13) where a stronger association among ER-negative than ER-positive breast cancers was observed. Importantly, the magnitude of effect in this TN study [OR=1.29, 95% CI 1.17 – 1.42] was identical to that reported for ER-negative breast cancer in the Chinese study [OR=1.29, 95% CI 1.21-1.37]. In contrast, a study of women of European ancestry did not observe an association with breast cancer, although analyses were not stratified by ER status (28). When combined with our results the suggestion is that this SNP may be specifically associated with TN or ER-negative disease. The second variant in the *ESR1* locus, rs12662670, was originally associated with breast cancer in the same study of women of European ancestry [OR=1.12, 95% CI 1.03 – 1.21] and was used as a surrogate for rs9397435 , which is associated with breast cancer risk [OR=1.15, 95% CI 1.06 – 1.25] independently of rs2046210 (28). Here rs12662670 showed a strong influence on TN breast cancer risk [OR=1.33, 95% CI 1.15 – 1.53] again suggesting that variation in the ESR1 loci is specifically associated with risk of ER-negative and/or TN breast cancer. It remains to be determined whether a single locus represented by rs2046210 or two loci accounted for by rs2046210 and rs9397435, are associated with ER-negative and TN breast cancer at chromosome 6q25.

Since TN breast cancer is defined in part by the absence of expression of estrogen receptors, we can speculate that inherited variation may down-regulate ESR1 expression and promote formation of ERα negative tumors. However, recent studies in mice have shown that the mammary stem cell compartment can be regulated by 17β-estradiol and progesterone through a paracrine-signalling mechanism from steroid receptor-positive luminal cells to steroid receptor-negative stem cells (29, 30). Thus, SNPs in the ESR1 locus may promote expansion of receptor negative precursors and subsequent development of TN tumors. Interestingly, variation in the 5’ region of *ESR1* has been associated with an increased risk

of breast cancer relapse in a British prospective cohort study (31), which was accounted for by including tumor grade and nodal status in multivariate models. Thus the causal SNPs in this area may be associated with a more aggressive tumor phenotype.

The SNPs rs8170 ($p=2.25 \times 10^{-8}$) and rs8100241 ($p=8.66 \times 10^{-7}$) located at 19p13.1 were first identified as modifiers of breast cancer risk in *BRCA1* carriers (15) and as risk factors for ovarian cancer (32) and were also shown to be significantly associated with ER-negative breast cancer (15). In this study we showed that rs8170 displayed a genome wide significant association with TN breast cancer, suggesting that we can now identify variation in the 19p13.1 locus as a risk factor for TN disease. Interestingly, rs8170 attenuated the significance of rs8100241 when the SNPs were included in a multivariate regression model for breast cancer, whereas these both SNPs retained significance in multivariate models evaluating effects on BRCA1 associated breast cancer and ER-negative breast cancer (15). In addition, our data suggest that these SNPs have a multiplicative effect on TN breast cancer risk. Further studies are required to determine whether these SNPs represent independent signals in the 19p13.1 locus. Additional studies are also needed to identify the underlying causative genetic events in this locus and to determine if the causative events for *BRCA1*, ER-negative, and TN breast cancer as well as ovarian cancer are in common.

These 19p13.1 variants are located in a cluster of genes including *C19orf62*, *ANKLE1*, and *ABHD8*. *ABHD8* encodes the abhydrolase domain containing 8 protein, which is a gene of uncharacterized function, and is located about 13 kb downstream of both rs8170 and rs8100241. The SNP rs8170 is located within *C19orf62*, which encodes the MERIT40 protein, while rs8100241 is located within *ANKLE1*, a protein of unknown function which encodes ankyrin repeat and LEM domains. MERIT40 is the most plausible candidate in this region for breast cancer susceptibility because it is a component of the BRCA1-A complex and is required to ensure the integrity and localization of this complex during the repair of DNA double-strand breaks, specifically through the recruitment and retention of the BRCA1-BARD1 ubiquitin ligase and the BRCC36 deubiquitination enzyme (33-35). However, it remains to be determined whether the causal variants at 19p13.1 alter MERIT40 expression or function or influence other genes in the region such as *ANKLE1* or *ABHD8*.

We also found that variants in *RAD51L1* (rs999737, $p=2.96 \times 10^{-4}$) and *TOX3* (rs3803662, $p=3.66 \times 10^{-5}$) were strongly associated with risk of TN breast cancer. Rs999737 (*RAD51L1*) was originally identified in a recent breast cancer GWAS of women of European ancestry (12). Detailed studies of breast tumors have suggested that rs999737 is associated with both ER-positive and ER-negative breast cancer, which is consistent with our findings. *RAD51L1* is a member of the Rad51-like family and functions in the double-strand break repair and homologous recombination pathway (36). When coupled with the association of the 19p13.1/MERIT40 locus with TN, the suggestion is that modification of DNA repair genes is an important mechanism involved in predisposition to TN breast cancer. The SNP rs3803662, located telomeric to the gene *TOX3*, was also strongly associated with TN breast cancer in our study ($p=3.66 \times 10^{-5}$). This SNP was originally identified in two GWAS of breast cancer (7, 9) and has been associated with risk of developing both ER-positive and ER-negative tumors (9). The SNP is also associated with risk of *BRCA1* related breast cancers (15), which are primarily ER-negative or TN. *TOX3* encodes a protein containing an HMG-box that is speculated to be involved in the modification of DNA and chromatin structure (37).

Only a subset of the 22 susceptibility loci were associated with TN disease in this study. This suggests that there may be heterogeneity in the predisposition loci associated with different breast tumor subtypes. However, it is important to consider whether limited statistical power may have influenced our results. Among the 16 SNPs that did not reach

statistical significance in this study, the effect estimates for variants at 1p11.2, 2q35, 8q24, 9q31.2, 10p15.1, 10q21.2/*ZNF365*, 10q22.3/*ZMIZ1*, and *FGFR2* showed either no evidence for association or were in the opposite direction compared to the original GWAS findings. Interestingly, 2q35 has been associated with both ER-negative (19) and BRCA1-related breast cancer (21), and was marginally significant in a smaller set of TN breast cancer (19). However, we found no evidence for association at 2q35 among TN breast cancer, indicating that risk for this locus may be limited to non-TN, ER-negative breast cancer. In contrast, the ORs for SNPs at *CASP8*, 9p21.3, and *COX11* were comparable in magnitude to the original GWAS findings, while the ORs for variants at 3p24/*NEK10*, 5p12, *MAP3K1*, *LSP1*, and 11q13 had only mildly attenuated effects. Our results are also consistent with a recent study reporting associations between *MAP3K1*, 3p24/*NEK10*, *COX11*, and *CASP8* and ER-negative breast cancer (19). These results suggest that we may have had insufficient power to detect significant associations for these SNPs among TN breast cancers.

Several limitations should be considered when interpreting these results. First, different ascertainment criteria were used among the contributing breast cancer studies with cases being ascertained from population-based or hospital-based case-control studies. Importantly, genetic main effects models in other large breast cancer consortia such as BCAC have provided stable risk estimates for SNPs across a wide range of study designs. This would suggest that in the case of these genetic variants, ascertainment and study design issues had limited influence on the results of genetic association studies for breast cancer. The consistency in effect estimates among BRCA1-related breast cancers, ER negative breast cancer, and now triple negative breast cancer for variants at 19p13.1, 6q25, and *TOX3* provide additional evidence that these estimates are robust to variability in study design. Further, our evaluation of interactions with age was underpowered, and unavailability of family history on the majority of studies precluded investigations of interactions by family history. There is also variability in the criteria used to define ER, PR, and HER2 status of cases between studies (**Supplementary Table 2**). For HER2, cases with scores of 0 or 1 by IHC were defined as HER2 negative. Cases with IHC of 2+ were not included in order to minimize erroneous inclusion of HER2 positive cases. In general, cases were considered ER or PR negative based on IHC of tumors using thresholds of <1% of cells stained, <10% of cells stained, or an Allred score of 0-2, which incorporates both intensity and percentage of staining in tumor cells. In addition to variability in thresholds for positivity, factors such as tissue fixation, antibody choice, and interpretation of positive immunostaining may also affect the definition or ER or PR status across study sites (38, 39). The resulting heterogeneity in the definition of triple negative breast cancer may influence our ability to detect associations with susceptibility loci that are specific to triple negative or ER negative disease. However, we did successfully identify six genetic loci associated with triple negative disease, and the lack of heterogeneity in effect estimates across study sites in this analysis (Figure 1) would suggest that our findings are generally robust to the differences noted above. Additionally, in a sensitivity analysis including only cases from studies with the most stringent criteria for defining TN cases (<1% of cells stained positive for ER and PR, HER2 0 or 1+ on IHC), the effect estimates were very similar to those from the complete analysis for the six SNPs in *ESR1*, 19p13.11, *TOX3*, and *RAD51L1*, with some attenuation of significance. Finally, it is important to note that the results of this study are specific to Caucasian women. While greater proportions of African Americans and Latinas than Caucasians develop TN breast cancer, it is not known whether similar associations with the SNPs described here exist in these populations. Further studies are needed to address this question.

In conclusion, our study provides convincing evidence for genetic susceptibility to TN breast cancer and suggests that susceptibility loci may differ by histological breast tumor subtype, defined by ER, PR and HER2 status. These findings add to the evidence suggesting

that these subtypes likely arise through distinct etiologic pathways. Additional studies, such as those from the Breast Cancer Association Consortium, will be important for determining whether these SNPs are exclusively associated with ER-negative, TN disease, or even basal breast cancer, a more refined subgroup of TN tumors. Fine mapping and functional analyses of these susceptibility loci are needed to identify the casual variants and mechanisms underlying the associations with TN breast cancer risk.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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References

1. Foulkes WD, Smith IE, Reis-Filho JS. Triple-negative breast cancer. N Engl J Med. 2010; 363:1938–48. [PubMed: 21067385]
2. Yang XR, Sherman ME, Rimm DL, Lissowska J, Brinton LA, Peplonska B, et al. Differences in risk factors for breast cancer molecular subtypes in a population-based study. Cancer Epidemiol Biomarkers Prev. 2007; 16:439–43. [PubMed: 17372238]

3. Schneider BP, Winer EP, Foulkes WD, Garber J, Perou CM, Richardson A, et al. Triple-negative breast cancer: risk factors to potential targets. Clin Cancer Res. 2008; 14:8010–8. [PubMed: 19088017]
4. Millikan RC, Newman B, Tse CK, Moorman PG, Conway K, Dressler LG, et al. Epidemiology of basal-like breast cancer. Breast Cancer Res Treat. 2008; 109:123–39. [PubMed: 17578664]
5. Bauer KR, Brown M, Cress RD, Parise CA, Caggiano V. Descriptive analysis of estrogen receptor (ER)-negative, progesterone receptor (PR)-negative, and HER2-negative invasive breast cancer, the so-called triple-negative phenotype: a population-based study from the California cancer Registry. Cancer. 2007; 109:1721–8. [PubMed: 17387718]
6. Irvin WJ Jr. Carey LA. What is triple-negative breast cancer? Eur J Cancer. 2008; 44:2799–805. [PubMed: 19008097]
7. Easton DF, Pooley KA, Dunning AM, Pharoah PD, Thompson D, Ballinger DG, et al. Genome-wide association study identifies novel breast cancer susceptibility loci. Nature. 2007; 447:1087–93. [PubMed: 17529967]
8. Hunter DJ, Kraft P, Jacobs KB, Cox DG, Yeager M, Hankinson SE, et al. A genome-wide association study identifies alleles in FGFR2 associated with risk of sporadic postmenopausal breast cancer. Nat Genet. 2007; 39:870–4. [PubMed: 17529973]
9. Stacey SN, Manolescu A, Sulem P, Rafnar T, Gudmundsson J, Gudjonsson SA, et al. Common variants on chromosomes 2q35 and 16q12 confer susceptibility to estrogen receptor-positive breast cancer. Nat Genet. 2007; 39:865–9. [PubMed: 17529974]
10. Stacey SN, Manolescu A, Sulem P, Thorlacius S, Gudjonsson SA, Jonsson GF, et al. Common variants on chromosome 5p12 confer susceptibility to estrogen receptor-positive breast cancer. Nat Genet. 2008; 40:703–6. [PubMed: 18438407]
11. Ahmed S, Thomas G, Ghoussaini M, Healey CS, Humphreys MK, Platte R, et al. Newly discovered breast cancer susceptibility loci on 3p24 and 17q23.2. Nat Genet. 2009; 41:585–90. [PubMed: 19330027]
12. Thomas G, Jacobs KB, Kraft P, Yeager M, Wacholder S, Cox DG, et al. A multistage genome-wide association study in breast cancer identifies two new risk alleles at 1p11.2 and 14q24.1 (RAD51L1). Nat Genet. 2009; 41:579–84. [PubMed: 19330030]
13. Zheng W, Long J, Gao YT, Li C, Zheng Y, Xiang YB, et al. Genome-wide association study identifies a new breast cancer susceptibility locus at 6q25.1. Nat Genet. 2009; 41:324–8. [PubMed: 19219042]
14. Turnbull C, Ahmed S, Morrison J, Pernet D, Renwick A, Maranian M, et al. Genome-wide association study identifies five new breast cancer susceptibility loci. Nat Genet. 2010; 42:504–7. [PubMed: 20453838]
15. Antoniou AC, Wang X, Fredericksen ZS, McGuffog L, Tarrell R, Sinilnikova OM, et al. A locus on 19p13 modifies risk of breast cancer in BRCA1 mutation carriers and is associated with hormone receptor-negative breast cancer in the general population. Nat Genet. 2010; 42:885–92. [PubMed: 20852631]
16. Fletcher O, Johnson N, Orr N, Hosking FJ, Gibson LJ, Walker K, et al. Novel Breast Cancer Susceptibility Locus at 9q31.2: Results of a Genome-Wide Association Study. J Natl Cancer Inst. 2011
17. Garcia-Closas M, Chanock S. Genetic susceptibility loci for breast cancer by estrogen receptor status. Clin Cancer Res. 2008; 14:8000–9. [PubMed: 19088016]
18. Garcia-Closas M, Hall P, Nevanlinna H, Pooley K, Morrison J, Richesson DA, et al. Heterogeneity of breast cancer associations with five susceptibility loci by clinical and pathological characteristics. PLoS Genet. 2008; 4:e1000054. [PubMed: 18437204]
19. Broeks A, Schmidt MK, Sherman ME, Couch FJ, Hopper JL, Dite GS, et al. Low penetrance breast cancer susceptibility loci are associated with specific breast tumor subtypes: findings from the Breast Cancer Association Consortium. Hum Mol Genet. 2011
20. Antoniou AC, Spurdle AB, Sinilnikova OM, Healey S, Pooley KA, Schmutzler RK, et al. Common breast cancer-predisposition alleles are associated with breast cancer risk in BRCA1 and BRCA2 mutation carriers. Am J Hum Genet. 2008; 82:937–48. [PubMed: 18355772]

21. Antoniou AC, Beesley J, McGuffog L, Sinilnikova OM, Healey S, Neuhausen SL, et al. Common breast cancer susceptibility alleles and the risk of breast cancer for BRCA1 and BRCA2 mutation carriers: implications for risk prediction. Cancer Res. 2010; 70:9742–54. [PubMed: 21118973]
22. Cox A, Dunning AM, Garcia-Closas M, Balasubramanian S, Reed MW, Pooley KA, et al. A common coding variant in CASP8 is associated with breast cancer risk. Nat Genet. 2007; 39:352–8. [PubMed: 17293864]
23. Milne RL, Gaudet MM, Spurdle AB, Fasching PA, Couch FJ, Benitez J, et al. Assessing interactions between the associations of common genetic susceptibility variants, reproductive history and body mass index with breast cancer risk in the Breast Cancer Association Consortium: a combined case-control study. Breast Cancer Res. 2010; 12:R110. [PubMed: 21194473]
24. Li J, Humphreys K, Darabi H, Rosin G, Hannelius U, Heikkinen T, et al. A genome-wide association scan on estrogen receptor-negative breast cancer. Breast Cancer Res. 2010; 12:R93. [PubMed: 21062454]
25. Leu M, Humphreys K, Surakka I, Rehnberg E, Muilu J, Rosenstrom P, et al. NordicDB: a Nordic pool and portal for genome-wide control data. Eur J Hum Genet. 2010; 18:1322–6. [PubMed: 20664631]
26. DerSimonian R, Laird N. Meta-analysis in clinical trials. Control Clin Trials. 1986; 7:177–88. [PubMed: 3802833]
27. Higgins JP, Thompson SG, Deeks JJ, Altman DG. Measuring inconsistency in meta-analyses. BMJ. 2003; 327:557–60. [PubMed: 12958120]
28. Stacey SN, Sulem P, Zanon C, Gudjonsson SA, Thorleifsson G, Helgason A, et al. Ancestry-shift refinement mapping of the C6orf97-ESR1 breast cancer susceptibility locus. PLoS Genet. 2010; 6:e1001029. [PubMed: 20661439]
29. Asselin-Labat ML, Vaillant F, Sheridan JM, Pal B, Wu D, Simpson ER, et al. Control of mammary stem cell function by steroid hormone signalling. Nature. 2010; 465:798–802. [PubMed: 20383121]
30. Joshi PA, Jackson HW, Beristain AG, Di Grappa MA, Mote PA, Clarke CL, et al. Progesterone induces adult mammary stem cell expansion. Nature. 2010; 465:803–7. [PubMed: 20445538]
31. Tapper W, Hammond V, Gerty S, Ennis S, Simmonds P, Collins A, et al. The influence of genetic variation in 30 selected genes on the clinical characteristics of early onset breast cancer. Breast Cancer Res. 2008; 10:R108. [PubMed: 19094228]
32. Bolton KL, Tyrer J, Song H, Ramus SJ, Notaridou M, Jones C, et al. Common variants at 19p13 are associated with susceptibility to ovarian cancer. Nat Genet. 2010; 42:880–4. [PubMed: 20852633]
33. Feng L, Huang J, Chen J. MERIT40 facilitates BRCA1 localization and DNA damage repair. Genes Dev. 2009; 23:719–28. [PubMed: 19261748]
34. Shao G, Patterson-Fortin J, Messick TE, Feng D, Shanbhag N, Wang Y, et al. MERIT40 controls BRCA1-Rap80 complex integrity and recruitment to DNA double-strand breaks. Genes Dev. 2009; 23:740–54. [PubMed: 19261746]
35. Wang B, Hurov K, Hofmann K, Elledge SJ. NBA1, a new player in the Brca1 A complex, is required for DNA damage resistance and checkpoint control. Genes Dev. 2009; 23:729–39. [PubMed: 19261749]
36. Lio YC, Mazin AV, Kowalczykowski SC, Chen DJ. Complex formation by the human Rad51B and Rad51C DNA repair proteins and their activities in vitro. J Biol Chem. 2003; 278:2469–78. [PubMed: 12427746]
37. O'Flaherty E, Kaye J. TOX defines a conserved subfamily of HMG-box proteins. BMC Genomics. 2003; 4:13. [PubMed: 12697058]
38. Gown AM. Current issues in ER and HER2 testing by IHC in breast cancer. Mod Pathol. 2008; 21(Suppl 2):S8–S15. [PubMed: 18437174]
39. Allred DC, Carlson RW, Berry DA, Burstein HJ, Edge SB, Goldstein LJ, et al. NCCN Task Force Report: Estrogen Receptor and Progesterone Receptor Testing in Breast Cancer by Immunohistochemistry. J Natl Compr Canc Netw. 2009; 7(Suppl 6):S1–S21. quiz S2-3. [PubMed: 19755043]

40. Ambrosone CB, Nesline MK, Davis W. Establishing a cancer center data bank and biorepository for multidisciplinary research. Cancer Epidemiol Biomarkers Prev. 2006; 15:1575–7. [PubMed: 16985014]

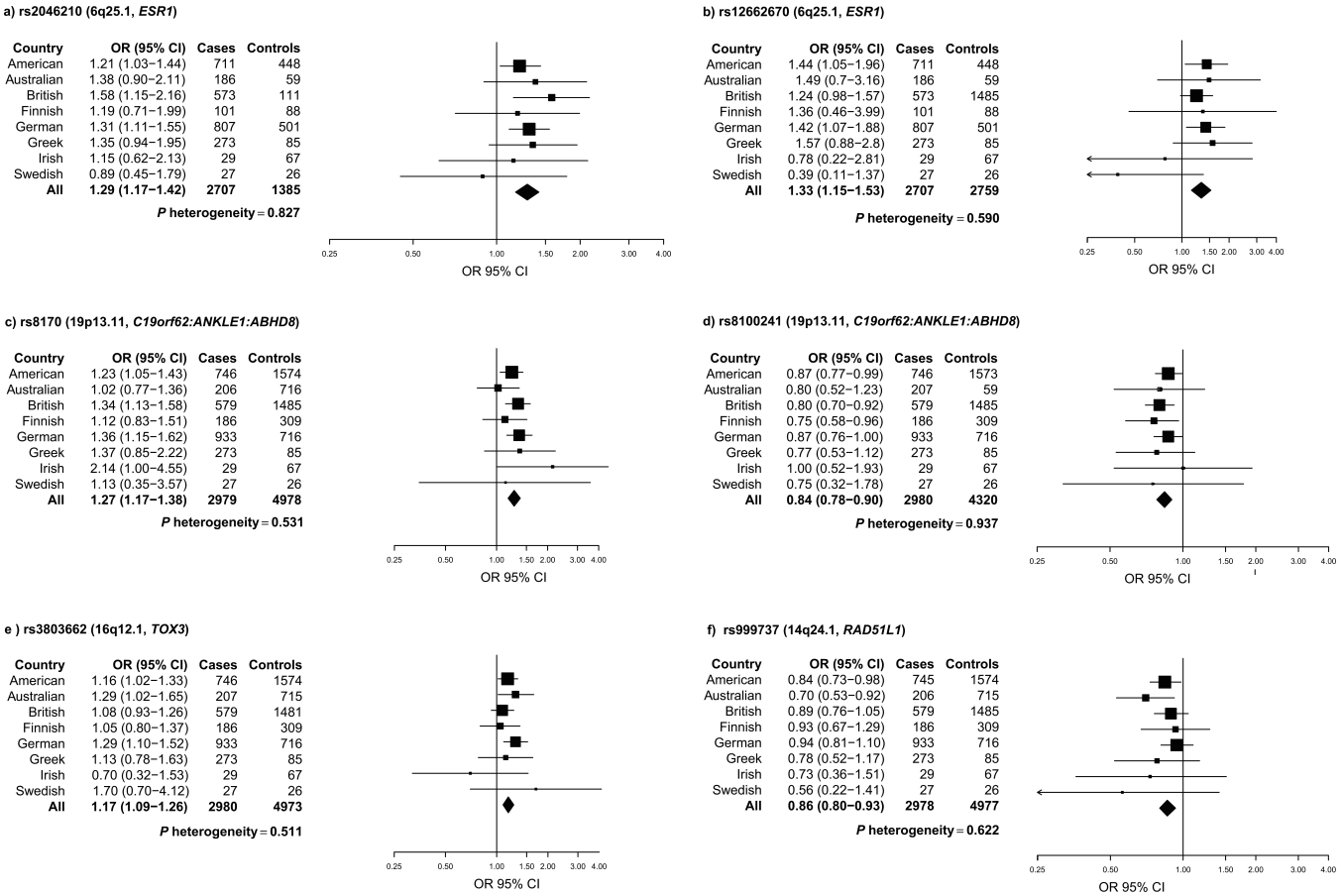

Figure 1. Breast cancer susceptibility loci and risk of TN breast cancer

Forest plots for six breast cancer susceptibility loci and risk of TN breast cancer are shown by country. Country-specific odds ratios (95% CIs) are denoted by black boxes (black lines). Overall OR estimates are represented by black diamonds, where diamond width corresponds to 95% CI bounds. Box and diamond heights are inversely proportional to precision of the OR estimate. I^2 values were 0 for each of these 6 SNPs, indicating no heterogeneity by country.

Table 1

Subjects by country and genotyping platform (iPLEX, GWAS)

Country	No. of studies	Age range (mean)[a]		Years of diagnosis[a]	iPLEX			GWAS			Combined		
		Cases	Controls		Cases	Controls	Total	Cases	Controls	Total	Cases	Controls	Total
U.S.A	5	25 - 92 (52)	24 - 92 (62)	1990 - 2010	711	448	1159	35	1126	1161	746	1574	2320
Australia	3	25 - 91 (56)	29 - 72 (46)	1990 - 2009	186	59	245	21	657	678	207	716	923
U.K.	5	22 - 93 (45)	42 - 81 (53)	1971 - 2010	573	111	684	6	1374	1380	579	1485	2064
Finland	3	27 - 90 (55)	18 - 80 (57)	1990 - 2004	101	88	189	85	221	306	186	309	495
Germany	6	22 - 88 (57)	24 - 81 (58)	1993 - 2008	740	501	1241	126	215	341	866	716	1582
Greece	1	21 - 79 (53)	34 - 82 (50)	1997 - 2010	273	85	358	0	0	0	273	85	358
Netherlands	1	26 - 62 (39)	NA	1995 - 2007	67	0	67	0	0	0	67	0	67
Sweden	1	48 - 88 (62)	48 - 85 (62)	1998 - 2000	27	26	53	0	0	0	27	26	53
Total	**25**	21 - 93 (52)	18 - 92 (56)	1971 - 2010	**2707**	**1385**	**4092**	**273**	**3593**	**3866**	**2980**	**4978**	**7958**

[a] Study-specific distributions shown in Supplementary Table 1

Table 2

Breast cancer susceptibility SNP (n=22) associations with TN breast cancer in a log-additive model

SNP	Gene/Locus	Chr	Tested (Minor) Allele	Overall				iPLEX				Published OR (95% CI)
				Cases	Controls	P-trend	OR (95% CI)	Cases	Controls	P-trend	OR (95% CI)	
rs11249433	*1p11.2*	1p11.2	G	2976	4968	0.27	0.96 (0.90-1.03)	2707	1385	0.54	0.97 (0.88-1.07)	1.16 (1.09-1.24) (12)
rs17468277[a]	*CASP8*	2q33.1	T	2979	4977	0.005	0.87 (0.78-0.96)	2707	1385	0.16	0.90 (0.78-1.04)	0.88 (0.84-0.92) (22)
rs13387042	*2q35*	2q35	G	2977	4976	0.26	0.96 (0.90-1.03)	2705	1384	0.92	0.99 (0.91-1.09)	1.20 (1.14-1.26) (9)
rs4973768	*SLC4A7:NEK10*	3p24	T	2960	4974	0.24	1.04 (0.97-1.12)	2688	1382	0.21	1.06 (0.97-1.17)	1.11 (1.08-1.13) (11)
rs10941679	*MRPS30:FGF10*	5p12	G	2705	1385	0.43	1.04 (0.94-1.16)	2705	1385	0.43[b]	1.04 (0.94-1.16)	1.19 (1.11-1.28) (10)
rs889312	*MAP3K1*	5q11.2	C	2844	2757	0.13	1.07 (0.98-1.17)	2707	1385	0.20	1.07 (0.97-1.19)	1.12 (1.08-1.16) (7)
rs2046210	*ESR1*	6q25.1	A	2707	1385	4.38×10^{-7}	1.29 (1.17-1.42)	2707	1385	4.38×10^{-7}[b]	1.29 (1.17-1.42)	1.15[c] (1.03-1.28) (13)
rs12662670	*ESR1*	6q25.1	G	2707	2759	1.13×10^{-4}	1.33 (1.15-1.53)	2707	1385	3.52×10^{-4}	1.37 (1.15-1.62)	1.18 (1.10-1.26) (28)
rs13281615	*8q24*	8q24.21	G	2841	3413	0.79	0.99 (0.92-1.07)	2707	1385	0.70	0.98 (0.89-1.08)	1.08 (1.05-1.12) (7)
rs1011970[a]	*CDKN2BAS:CDKN2A:CDKN2B*	9p21.3	T	2979	4977	0.13	1.07 (0.98-1.17)	2707	1385	0.02	1.16 (1.02-1.31)	1.09 (1.04-1.14) (14)
rs865686	*LOC100128657*	9q31.2	G	2979	4971	0.65	1.02 (0.95-1.09)	2707	1385	0.96	1.00 (0.91-1.1)	0.89 (0.85-0.92) (16)
rs2380205	*ANKRD16:FBXO18*	10p15.1	T	2979	4974	0.71	0.99 (0.92-1.06)	2707	1385	0.94	1.00 (0.91-1.1)	0.94 (0.91-0.89) (14)
rs10509168	*ZNF365*	10q21.2	T	2980	4976	0.79	1.01 (0.94-1.08)	2707	1385	0.88	0.99 (0.90-1.09)	0.86 (0.82-0.91) (14)
rs704010	*ZMIZ1*	10q22.3	T	2964	4963	0.80	0.99 (0.93-1.06)	2692	1370	0.99	1.00 (0.91-1.1)	1.07 (1.03-1.11) (14)
rs2981582	*FGFR2*	10q26	A	2707	2756	0.24	0.95 (0.88-1.03)	2707	1385	0.64	0.98 (0.89-1.08)	1.26 (1.22-1.29) (7)
rs3817198	*LSP1*	11p15.5	C	2929	4756	0.49	1.03 (0.95-1.10)	2707	1385	0.68	1.02 (0.92-1.13)	1.07 (1.04-1.11) (7)
rs614367	*MYEOV:CCND1*	11q13	T	2926	4749	0.17	1.07 (0.97-1.18)	2707	1385	0.12	1.12 (0.97-1.28)	1.15 (1.10-1.20) (14)
rs999737	*RAD51L1*	14q24.1	T	2978	4977	2.96×10^{-4}	0.86 (0.80-0.93)	2706	1385	0.05	0.90 (0.80-1.00)	0.94 (0.88-0.99) (12)
rs3803662	*TOX3*	16q12.1	A	2980	4973	3.66×10^{-5}	1.17 (1.09-1.26)	2707	1385	8.25×10^{-4}	1.20 (1.08-1.33)	1.19 (1.15-1.23) (7)
rs6504950	*COX11*	17q23.2	A	2707	1385	0.54	0.97 (0.87-1.07)	2707	1385	0.54[b]	0.97 (0.87-1.07)	0.95 (0.92-0.97) (11)
rs8170	*C19orf62:ANKLE1*	19p13.1	T	2979	4978	2.25×10^{-8}	1.27 (1.17-1.38)	2707	1385	7.30×10^{-8}	1.40 (1.24-1.58)	1.26 (1.17-1.35) (21)
rs8100241	*C19orf62:ANKLE1*	19p13.1	A	2980	4320	8.66×10^{-7}	0.84 (0.78-0.90)	2707	1385	1.81×10^{-6}	0.79 (0.71-0.87)	0.84 (0.80-0.89) (21)

[a] These SNPs showed evidence of country-based heterogeneity.

[b] No additional samples included in overall analysis compared to iPLEX-only

[c] Estimated OR in Europeans