TPOAb and thyroid function are not associated with breast cancer outcome; evidence from a large-scale study using data from the Taxotere as Adjuvant Chemotherapy Trial (TACT, CRUK01/001)

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ABSTRACT

Background: Small-scale studies correlated the presence of thyroid autoimmunity with both improved or worsened breast cancer outcome.

Objectives: We aimed to clarify this association in a large cohort using the phase-III randomized controlled "Taxotere as Adjuvant Chemotherapy Trial" (TACT, CRUK01/001).

Methods: TACT women >18-years-old with node-positive or high risk node-negative early breast cancer (pT1-3a,pN0-1,M0), with stored plasma (n=1974), taken 15.5 [7.0-24.0] months (median [IQR]) after breast surgery were studied. Patients had also received chemotherapy (100%), radiotherapy (1745/1974 [88.4%]), hormonal therapy (1378/1974 [69.8%]), or trastuzumab (48/1974 [2.4%]). History of thyroid diseases and/or related treatments was not available.

The prognostic significance of autoantibodies to thyroid peroxidase (TPOAb; positive ≥6 kIU/L), free-thyroxine and thyrotropin (combined: euthyroid, hypothyroid, hyperthyroid) was evaluated for disease-free survival (DFS), overall-survival (OS), time-to-recurrence (TTR), with Cox regression models in univariate and multivariable analyses. The extended median follow-up was 97.5 months.

Results: No difference in DFS was found by TPOAb status (unadjusted-hazard ratio [HR]: 0.97, 95%CI: 0.78-1.19, P=0.75) and/or thyroid function (unadjusted-HR [hypothyroid versus euthyroid]: 1.15, 95%CI: 0.79-1.68, P=0.46; unadjusted-HR [hyperthyroid versus euthyroid]: 1.14, 95%CI: 0.82-1.61, P=0.44). Similar results were obtained for OS, TTR, multivariable analyses, when TPOAb titre by tertiles was considered and in a subgroup of 123 patients with plasma collected before adjuvant treatments.

Conclusions: No evidence for a prognostic role of TPOAb and/or thyroid function in moderate-high risk early breast cancer was found in the largest and longest observational study to date.

INTRODUCTION

An association between breast cancer (BC) and benign thyroid disorders has been debated for decades, reported in several [1,2], but not all [3] studies; the most recent meta-analyses and reviews reached contrasting conclusions [1,4-6]. Hypothyroidism was found to correlate with both an increased [7,8] or reduced [9-11] risk of developing BC, whilst other authors did not report a significant correlation [12,13]. BC has been particularly associated with thyroid autoimmunity (TA); a higher prevalence of anti-thyroid peroxidase (TPO) autoantibodies (TPOAb) was found among BC patients, compared with healthy controls [8,14]. Furthermore, a better BC outcome has been reported in TPOAb positive (TPOAb+) versus TPOAb negative (TPOAb-) patients in some [15-18], but not all [19] studies.

Currently no validated major blood prognostic markers for BC are available; carcinoembryonic antigen and cancer antigen 15.3 are the most used, but have low specificity and sensitivity [20]. Circulating tumour DNA and tumour cells seem very promising markers, however further studies are needed to validate them in routine clinical practice [21]. It would therefore be valuable if TPOAb could be confirmed as a blood BC prognostic marker.

Two studies evaluated 5-year outcomes in 142 [15] and 47 [16] BC women: Smyth *et al.* [15] reporting TPOAb- as a poor prognostic factor for disease-free survival (DFS) and overall survival (OS), and Fiore *et al.* [16] reporting 6.7% mortality in patients positive for anti-thyroid autoantibodies (TAb), mainly TPOAb+, compared with 46.9% in TAb negative patients. Farahati *et al.* evaluated 314 newly diagnosed BC patients and found no distant metastases among TPOAb+ patients compared with 6.6% among TPOAb- patients [17]. In contrast, Jiskra et al. followed 84 BC patients for 136 months (median), finding no impact of TPOAb on DFS or OS [19].

The aim of the present study was to clarify the impact of TPOAb on BC prognosis in a large, well powered patient cohort with long-term follow-up, according to the "REporting recommendations for tumour MARKer prognostic studies (REMARK)" guidelines [22]. The

"Taxotere as Adjuvant Chemotherapy Trial (TACT)" recruited 4162 women diagnosed with moderate-high risk early BC, evaluating whether sequential docetaxel (Taxotere) after anthracycline therapy would improve patient outcome compared with standard anthracycline chemotherapy: analyses were conducted at 62 months [23] and 97.5 months [24] follow-up, both showing no evidence of a difference between the two chemotherapy regimens. Of relevance, stored plasma was available in a significant number of these patients.

Furthermore, TPO is expressed in BC tissue [25], providing a possible mechanistic link: a thyroid/breast shared autoimmune response might target tumour cells and improve BC outcome. If TPOAb+ was confirmed as associated with a better BC outcome, new BC therapeutic approaches based on antigen-specific immunotherapies targeting TPO could be explored.

MATERIALS AND METHODS

Patients

The TACT study [23] was a multicentre, open-label, phase-III, randomised controlled trial of women aged >18 years diagnosed with operable early BC (pT1-3a, pN0-1, M0), with indication for adjuvant chemotherapy, including both lymph-node positive (node+) patients and lymph-node negative (node-) but high risk (e.g., tumour grade 3, hormonal-receptor expression negative, or lymphovascular invasion) patients.

Between February 2001 and June 2003, 4162 women were enrolled across 103 UK and one Belgian centres. All subjects underwent surgery, mastectomy or wide-local-excision (WLE), and were randomized (1:1 ratio) to the experimental regimen FEC-D (n=2073; fluorouracil, epirubicin, cyclophosphamide [FEC] followed by docetaxel) or centre's choice of control chemotherapy, either FEC (n=1265) or E-CMF (n=824; epirubicin followed by CMF [cyclophosphamide, methotrexate, and fluorouracil]). Adjuvant radiotherapy was mandatory after WLE or used after mastectomy according to local guidelines. Endocrine

treatments (tamoxifen or aromatase-inhibitor monotherapy, tamoxifen followed by aromatase-inhibitor) were administered to patients with oestrogen receptor (ER) positive expression (ER+). Patients with human epidermal growth factor receptor-2 (HER2) positive expression (HER2+) were allowed to enter clinical trials assessing trastuzumab. All subjects have given their informed consent and the study protocol has been approved by the institute's committee on human research.

Laboratory measurements

Following a protocol amendment (November 2002), blood was taken for future translational research at the time of randomization, or at their next follow-up visit. Plasma samples were stored at -20°C for 6.5-13 years (range) at The Institute of Cancer Research (London, UK), and transferred to the Thyroid Research Group (Cardiff, UK) for TPOAb, thyrotropin (TSH) and free-thyroxine (FT4) analyses (October 2014) using an ADVIA Centaur automated immunoassay analyser (Bayer plc, UK) and Chemiluminescent Microparticle Immunoassay methods by the ARCHITECT® System (ABBOTT Laboratories, USA). According to the assay cut-off, TPOAb values were dichotomized as ≥6 kIU/L (positive: TPOAb+) versus <6 kIU/L (negative: TPOAb-); TPOAb+ were also categorized into tertiles. FT4 and TSH normal ranges were respectively 9.0–19.1 pmol/L and 0.30–4.40 mIU/L; they were also combined in a thyroid function status variable: euthyroid (FT4 and TSH within the normal ranges), hypothyroid (FT4 <9.0 pmol/L and/or TSH >4.40 mIU/L); hyperthyroid (FT4 >19.1 pmol/L and/or TSH <0.3 mIU/L).

Statistical analysis

According to TPOAb prevalence in age-matched females of general population [26,27], 20% of BC individuals were expected to be TPOAb+. Power calculations indicated 1158 and 1430 samples required to provide respectively 80% and 90% power to detect a 81%

5-year DFS in TPOAb+ versus 73% in TPOAb- subjects (HR, 0.64; two-sided log-rank test with a 0.05 probability of a type I error), consistent with a 74.9% 5-year DFS rate in the whole TACT cohort [23].

Baseline characteristics, BC treatments and DFS-related characteristics were compared between TACT patients included or not in this study, and presented by dichotomized TPOAb and thyroid function status. Correlations between thyroid biomarkers were assessed using the Spearman rank method.

The primary outcome was to assess TPOAb prognostic significance in relation to DFS; secondary outcomes were TPOAb prognostic significance in relation to OS and time-to-recurrence (TTR), and thyroid function in relation to DFS, OS and TTR.

For DFS, OS and TTR, Kaplan-Meier curves were plotted and biomarkers compared with the log-rank test, and assessed firstly in a univariate Cox proportional hazards regression model stratified by centre's choice of control chemotherapy regimen and ER status, and subsequently included in a multivariable Cox model along with known BC prognostic factors: age, HER2 status, nodal involvement, tumour size and tumour grade. Additional variables, i.e. trial treatment (experimental versus control), type of surgery, trastuzumab use, radiotherapy and menopausal status, were included if, by stepwise selection ($P<0.05$), shown to add value. TPOAb, TSH and FT4 were subsequently considered for inclusion if providing independent prognostic information. Interaction tests were used to explore differential effects within subgroups. HR with 95% CI were obtained, with $HR<1$ indicating a better BC prognosis.

All patients with a biomarker value available were included in the analysis, as per an intention-to-treat analysis. All analyses were conducted using Stata version 13.1 (STATACORP, TX) [23,24].

RESULTS

All available TACT plasma samples (N=2000) were analysed for thyroid biomarkers, and 1974 samples were considered for the statistical analyses ("analysis population"; **Supplemental Fig. 1**). The median (IQR; range) blood collection time was 15.5 (7.0-24.0; 0.5–57.2) months after surgery.

Supplemental Table 1 reports analysis population's characteristics; the median (IQR; range) follow-up was 96.7 (87.4-106.3; 3.4-126.4) months. Overall 5-year estimates for DFS, OS and TTR were 79.5% (95% CI, 77.6-81.2), 87.4% (95% CI, 85.9-88.8) and 81.1% (95% CI, 79.3-82.8), respectively.

Distribution of TPOAb and thyroid function

TPOAb+ was detected in 406/1974 (20.6%) patients, distributed in the following tertiles: 137 (6.9%) 6-40 kIU/L (T1), 134 (6.7%) 41-238 kIU/L (T2), 135 (6.8%) 240-2000 kIU/L (T3). Baseline characteristics were largely comparable between TPOAb+ and TPOAb- patients (**Table 1**), apart from age, with TPOAb+ patients slightly older than TPOAb- patients (mean [SD] age, 50.2 [7.7] years versus 48.8 [8.5] years, respectively; P=0.005).

Plasma material was sufficient to determine FT4 and TSH values in 1974/1974 (100%) and 1971/1974 (99.8%) samples respectively. Among the 1974 patients, 1760 (89.2%) were euthyroid, 96 (4.9%) hypothyroid and 118 (6.0%) hyperthyroid; all 3 subgroups had similar baseline characteristics (**Table 1**), apart from age, with hypothyroid and hyperthyroid patients slightly older than euthyroid patients (mean [SD] age, respectively 50.5 [6.6] years and 50.7 [7.6] years, versus 48.9 [8.5] years; P=0.03).

As shown in **Supplemental Fig. 2**, FT4 and TSH were inversely correlated (Spearman rank, -0.23; P<0.001) and TPOAb was positively associated with TSH (Spearman rank, 0.24; P<0.001). The inverse correlation between TPOAb and FT4 was weak (Spearman

rank, -0.04; P=0.09). TPOAb+ cases were more prevalent among hypothyroid and hyperthyroid patients compared with the euthyroid group (73/96 [76.0%] hypothyroid; 45/118 [38.1%] hyperthyroid; 288/1760 [16.4%] euthyroid; P<0.001).

TPOAb and BC prognosis

The majority of DFS events were related to distant recurrence in both TPOAb+ and TPOAb- groups (**Supplemental Table 2**). There was no evidence of a difference in DFS between TPOAb+ and TPOAb- patients (unadjusted-HR: 0.97, 95% CI: 0.78-1.19, P=0.75, **Fig. 1A**; adjusted-HR: 1.00, 95% CI: 0.81-1.24, P=0.98, **Table 2**). Subgroup analyses showed no evidence of any significant interaction effects (**Fig. 2**). Similarly, there was no evidence of a difference by TPOAb status on OS (unadjusted-HR: 0.86, 95% CI: 0.66-1.11, P=0.24, **Fig. 1B**; adjusted-HR: 0.89, 95% CI: 0.69-1.14, P=0.35, not shown) and TTR (unadjusted-HR: 0.97, 95% CI: 0.78-1.21, P=0.80, **Fig. 1C**; adjusted-HR: 1.02, 95% CI: 0.81-1.27, P=0.89, not shown). TPOAb+ tertiles showed no evidence of a prognostic effect in both univariate (**Fig. 3**) and multivariable (data not shown) analyses for DFS, OS and TTR.

Two sensitivity analyses included 126 node+ patients not treated with radiotherapy, similar to Fiore *et al.* cohort [16], and 123 patients with blood taken before any adjuvant therapy. The median (IQR; range) time of blood collection after surgery was 12.4 (4.9-21.6; 0.7–47.2) months and 1.1 (0.9-1.4; 0.5-5.9) months, respectively. There was no evidence of a significant impact on DFS by TPOAb status in either of the two analyses, with unadjusted-HRs of 1.48 (95% CI, 0.68-3.25; P=0.32) and 0.83 (95% CI, 0.35-2.03; P=0.69) respectively.

Thyroid function and BC prognosis

There was no evidence of a significant difference for DFS, OS and TTR by thyroid function status in either univariate (**Fig. 4**) or multivariable (data not shown) analyses, and

when considering FT4 and TSH separately (DFS, **Supplemental Table 3**; OS and TTR, not shown).

DISCUSSION

In this large cohort of moderate-high risk early BC patients receiving adjuvant systemic treatments we found that neither the presence nor the titre of plasma TPOAb, assessed after BC diagnosis and measured with standard assays, had a substantial impact on long-term recurrence or mortality; similar findings were observed for thyroid status. These results confirm one previous finding [19], but contrast with two other studies [15,16]. We believe that our study is reliable, considering that our patient cohort is the largest to date, with one of the longest follow-ups, and focused on a well-defined BC population. Previous studies used smaller patient cohorts with shorter follow-ups [15,16,19], mixed different BC stages [19], or provided no information about BC stage [15], histological [15,19] and molecular subtypes [15,16,19], and adjuvant treatments received [15,19]; they may be susceptible to bias and random findings. In addition, the BC population analysed in this study is very similar to that of Fiore *et al.,* who recruited non-metastatic aggressive BC all treated with chemotherapy [16].

The long survival of our patient cohort could obscure a minor prognostic effect of TPOAb and/or thyroid function on BC, hypothetically detectable only among patients not suitable for standard treatments (e.g. medical contraindications) and targeted therapies (e.g. triple negative BC). This is possible but unlikely, since our exploratory analysis conducted among different BC subtypes confirmed our negative results. Furthermore, the multivariable analyses confirmed nodal status and tumour size as the two most important BC prognostic factors [28], proving that the cohort used was appropriate for the research question, and the model reasonably sensitive. Similarly, the better BC prognosis characterizing the

intermediate age group (50-59 years) is consistent with the results of a recent large cohort study [29].

Our study cannot exclude a role of different TA parameters on BC prognosis, i.e. the presence of goitre [15] or incidental TA-related ^{18}F-FDG PET/CT uptake [18]. Furthermore, differences in the alternative splicing of TPO in the breast as compared to the thyroid have been described [25], therefore this might also result in different TPO epitopes being targeted.

TPOAb prevalence in our cohort, similar to our *a priori* predicted value, reflects TPOAb prevalence among women of general population [26,30], increasing with age [26,31]. It remains possible that TPOAb+ rates are higher in the BC population, as our study was not designed to compare TPOAb prevalence among BC patients and the general population.

The principal limitations of the present study are the lack of clinical history for thyroid diseases or medications and that, similarly to previous studies [15,19], blood was mainly collected during/after adjuvant BC therapy. The first limitation might influence the prognostic role of thyroid function, but marginally of TPOAb, since they should exert an effect when either pre-existing, or appearing at a later time [32]; however, the evidence that thyroid function influences BC outcome is weak [6]. The finding of more cases of hyper- (6.0%) than hypo-thyroidism (4.9%) may reflect over-treatment with levothyroxine in some individuals.

Regarding BC adjuvant treatments, an increased risk of hypothyroidism after chemotherapy [33,34] or radiotherapy [35,36] for BC has been suggested in a few small studies, but not confirmed by others [37]. Tamoxifen can exert a modulation of thyroid function, mainly via an anti-thyroid effect [38,39] and the stress related to the surgical procedure itself has been suggested to cause immunomodulation [40]. However no clear large-scale effects of adjuvant treatments for BC, including trastuzumab, on thyroid function and immunity have been described, and our sensitivity analysis in a subgroup of 123 patients

in whom blood was collected before BC adjuvant therapy showed no evidence of TPOAb prognostic ability, even if the wide 95% CI suggests a lack of statistical power.

To draw definitive conclusions, a prospective study collecting blood before cancer treatments would be ideal, but difficult to realise because of the large patient number required, as shown by our *a priori* power calculation. Furthermore, this study analysed moderate-high risk early BC only. BC is a heterogeneous disease, with many subtypes characterised by different clinical behaviour and prognosis; it could be possible that TPOAb and/or thyroid function affect the prognosis of certain specific BC subtypes and stages only, therefore they should be all investigated separately, with a much higher total patient numbers required to reach significant and definitive results.

In conclusion, the present study is to our knowledge the largest currently available investigating the impact of blood TPOAb and thyroid function on BC prognosis, providing a detailed description of the BC population analysed, and therefore representing a key-work to clarify this debate over decades. We found that TPOAb and thyroid function, both measured with standard assays and after BC diagnosis, appear not to influence substantially the long-term recurrence and mortality of moderate-high risk early BC in the modern era. Major confounding in this conclusion due to BC treatments seems unlikely. Future studies might explore different BC stages and/or specific subtypes, also searching for non-conventional or breast-specific immune responses to particular TPO epitopes, to determine whether aspects of TA other than standard TPOAb and thyroid function may be relevant to BC outcome.

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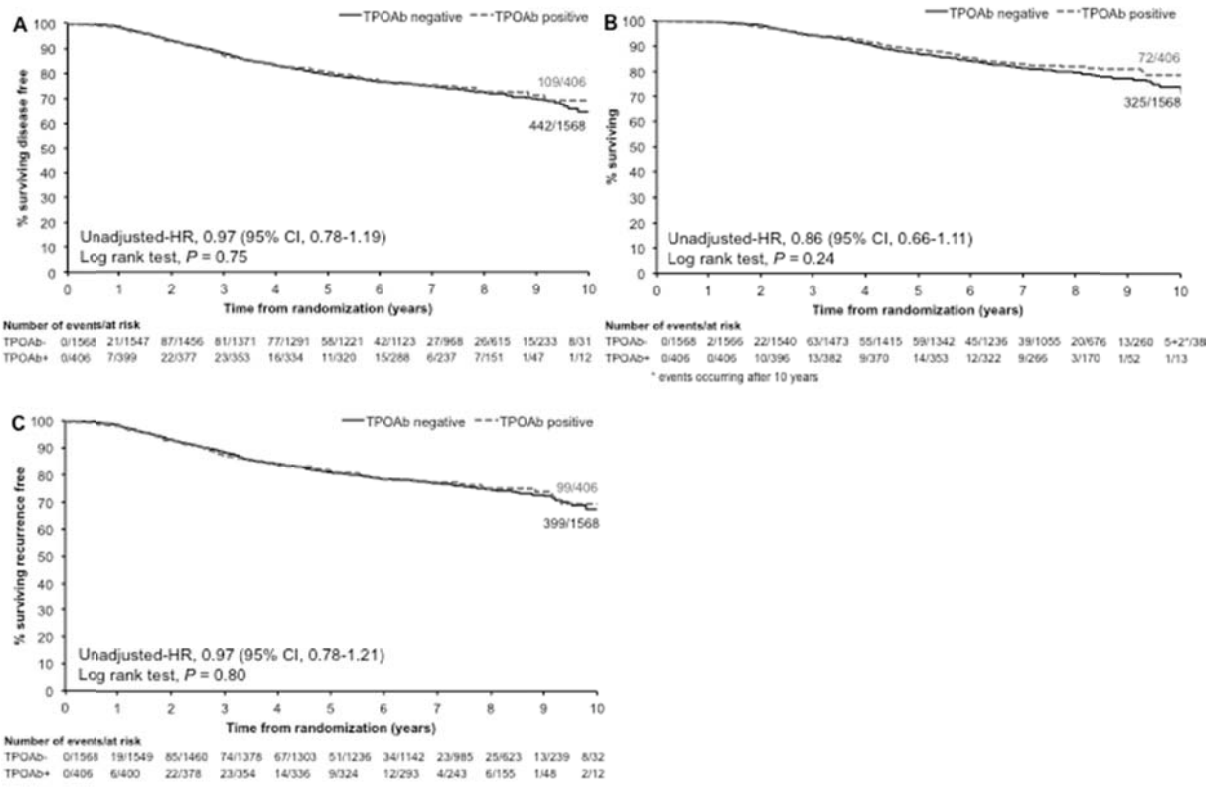
419

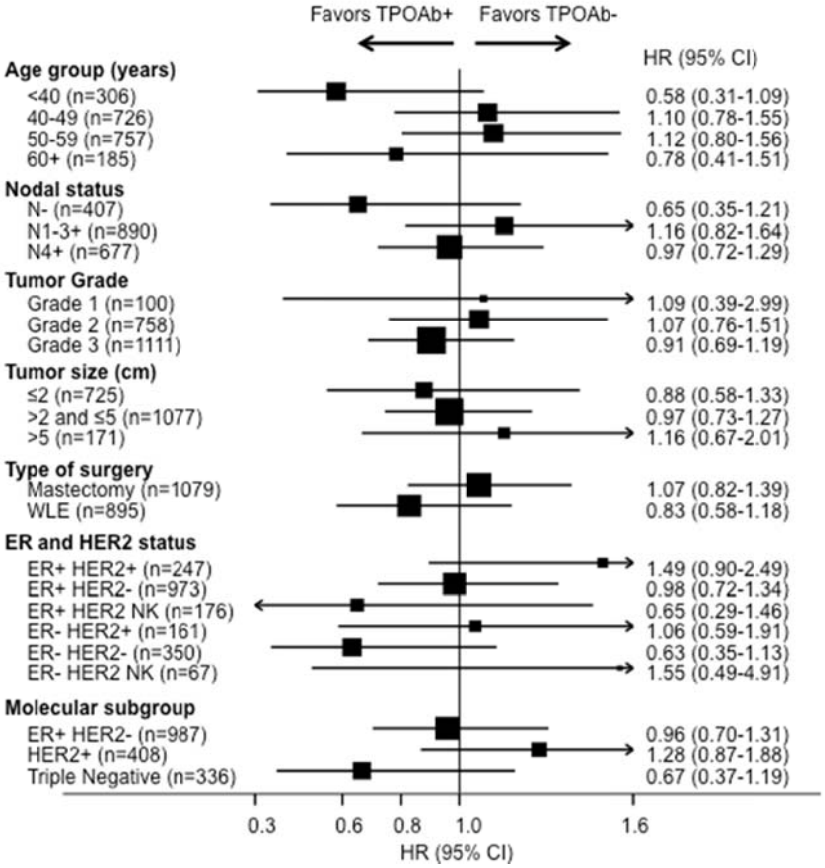
FIGURES

Fig. 1: Univariate analyses by dichotomized autoantibodies to thyroid peroxidase (TPOAb)



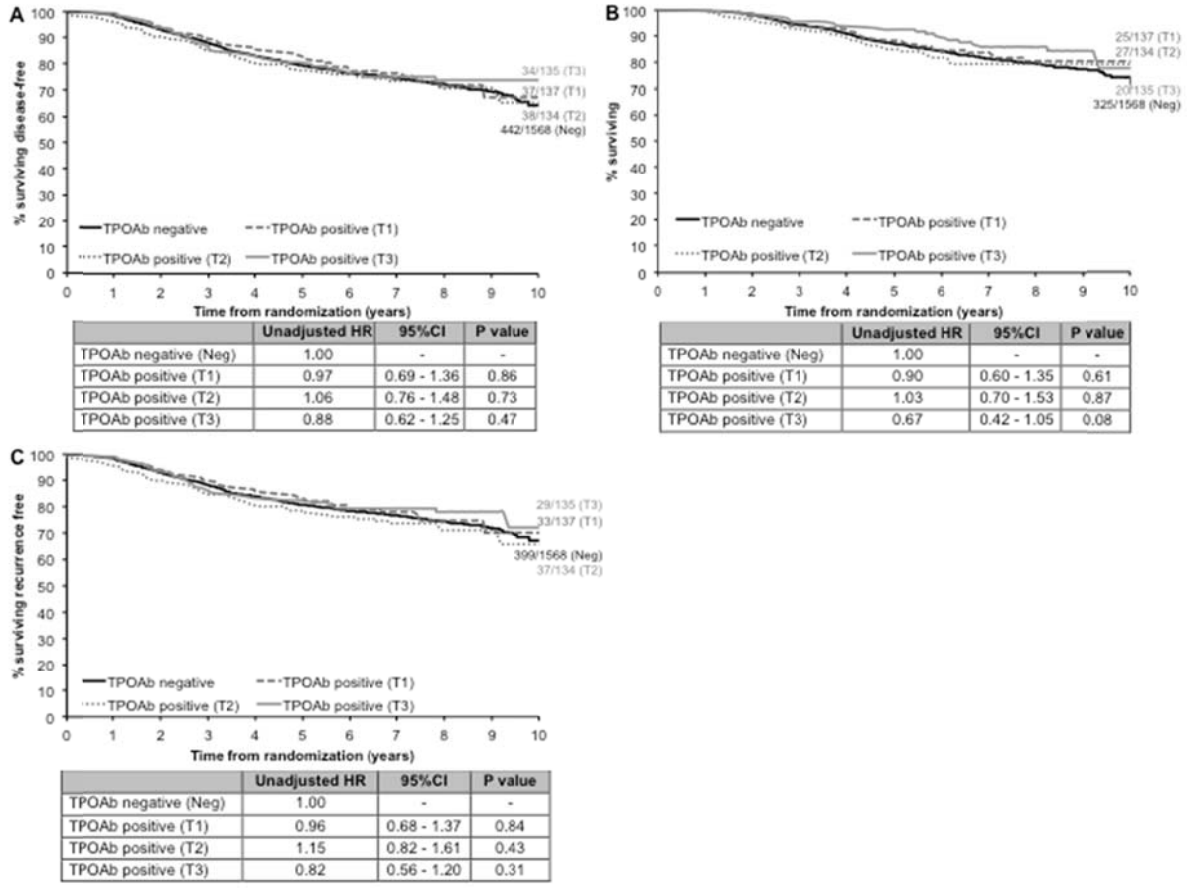
Kaplan-Meier curves relative to breast cancer (BC) outcome (median follow-up 96.7 months) in patients positive (≥6 kIU/L) and negative (<6 kIU/L) for TPOAb. HR, hazard ratio (HR <1 indicates a favorable BC outcome); 95% CI, 95% confidence interval. Panel A: disease-free survival (DFS). Panel B: overall survival (OS). Panel C: time to recurrence (TTR).

Fig. 2: Exploratory subgroup analyses for disease-free survival by dichotomized autoantibodies to thyroid peroxidase (TPOAb)



ER+, positive estrogen receptor (ER); ER-, negative ER; HER2+, positive human epidermal growth factor receptor-2 (HER2); HER2-, negative HER2; NK, not known; N-, lymph-node negative; N1-3+, 1-3 lymph-nodes positive, N4+, 4 or more lymph-nodes positive; TPOAb+, positive TPOAb; TPOAb-, negative TPOAb; triple negative, negative HER2, ER and progesterone receptor; WLE, wide local excision; 95% CI, 95% confidence interval.

Fig. 3: Univariate analyses by autoantibodies to thyroid peroxidase (TPOAb) categorized into tertiles



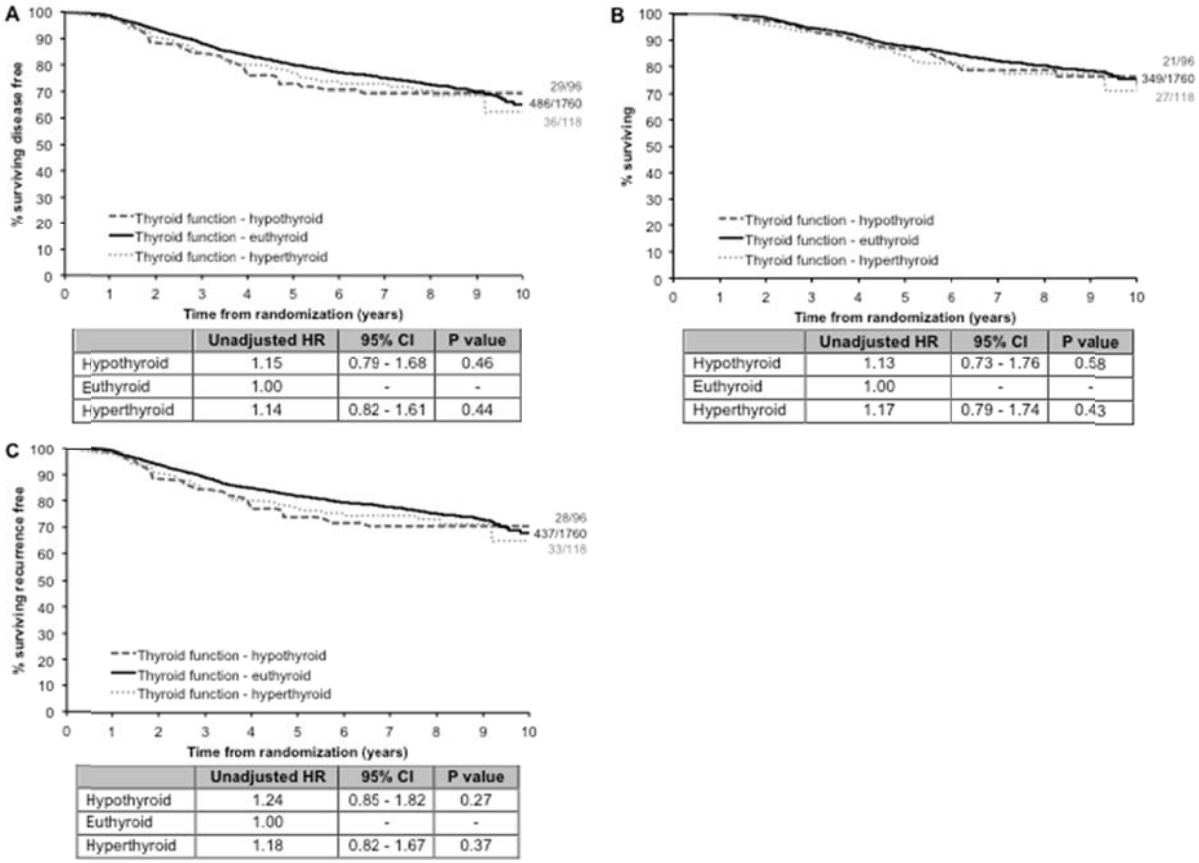
	Unadjusted HR	95%CI	P value
TPOAb negative (Neg)	1.00	-	-
TPOAb positive (T1)	0.97	0.69 - 1.36	0.86
TPOAb positive (T2)	1.06	0.76 - 1.48	0.73
TPOAb positive (T3)	0.88	0.62 - 1.25	0.47

	Unadjusted HR	95%CI	P value
TPOAb negative (Neg)	1.00	-	-
TPOAb positive (T1)	0.90	0.60 - 1.35	0.61
TPOAb positive (T2)	1.03	0.70 - 1.53	0.87
TPOAb positive (T3)	0.67	0.42 - 1.05	0.08

	Unadjusted HR	95%CI	P value
TPOAb negative (Neg)	1.00	-	-
TPOAb positive (T1)	0.96	0.68 - 1.37	0.84
TPOAb positive (T2)	1.15	0.82 - 1.61	0.43
TPOAb positive (T3)	0.82	0.56 - 1.20	0.31

Kaplan-Meier curves relative to breast cancer (BC) outcome (median follow-up 96.7 months) in patients negative (<6 kIU/L) and positive for TPOAb categorized into tertiles: 6-40 kIU/L (T1), 41-238 kIU/L (T2), 240-2000 kIU/L (T3). HR, hazard ratio (HR <1 indicates a favorable BC outcome); 95% CI, 95% confidence interval. Panel A: disease-free survival (DFS). Panel B: overall survival (OS). Panel C: time to recurrence (TTR).

Fig. 4: Univariate analyses by thyroid function status



	Unadjusted HR	95% CI	P value
Hypothyroid	1.15	0.79 - 1.68	0.46
Euthyroid	1.00	-	-
Hyperthyroid	1.14	0.82 - 1.61	0.44

	Unadjusted HR	95% CI	P value
Hypothyroid	1.13	0.73 - 1.76	0.58
Euthyroid	1.00	-	-
Hyperthyroid	1.17	0.79 - 1.74	0.43

	Unadjusted HR	95% CI	P value
Hypothyroid	1.24	0.85 - 1.82	0.27
Euthyroid	1.00	-	-
Hyperthyroid	1.18	0.82 - 1.67	0.37

Kaplan-Meier curves relative to breast cancer (BC) outcome (median follow-up 96.7 months) according to thyroid function status. Euthyroid, free-thyroxine (FT4) 9.0–19.1 pmol/L and thyrotropin (TSH) 0.30–4.40 mIU/L; hyperthyroid, FT4 >19.1 pmol/L and/or TSH <0.3 mIU/L; hypothyroid, FT4 <9.0 pmol/L and/or TSH >4.40 mIU/L. HR, hazard ratio (HR <1 indicates a favorable BC outcome); 95% CI, 95% confidence interval. Panel A: disease-free survival (DFS). Panel B: overall survival (OS). Panel C: time to recurrence (TTR).

461 **TABLES**
462

463 **Table 1: Baseline characteristics and treatments for breast cancer by autoantibodies to thyroid peroxidase (TPOAb) and thyroid function status**

	TPOAb- N = 1568	TPOAb+ N = 406	P value	Hypothyroid N = 96	Euthyroid N = 1760	Hyperthyroid N = 118	P value
Age (years): mean (SD)	48.8 (8.5)	50.2 (7.7)	0.005[a]	50.5 (6.6)	48.9 (8.5)	50.7 (7.6)	0.03[d]
Age group (years): n (%)							
<40	257 (16.4)	49 (12.1)		8 (8.3)	287 (16.3)	11 (9.3)	
40-49	575 (36.7)	151 (37.2)	0.08[b]	36 (37.5)	647 (36.8)	43 (36.4)	0.62[b]
50-59	590 (37.6)	167 (41.1)		45 (46.9)	657 (37.3)	55 (46.6)	
≥60	146 (9.3)	39 (9.6)		7 (7.3)	169 (9.6)	9 (7.6)	
Nodal status: n (%)							
Node negative	314 (20.0)	93 (22.9)	0.62[b]	18 (18.8)	367 (20.9)	22 (18.6)	0.61[b]
1-3 positive nodes	719 (45.9)	171 (42.1)		33 (34.4)	808 (45.9)	49 (41.5)	
≥4 positive nodes	535 (34.1)	142 (35.0)		45 (46.9)	585 (33.2)	47 (39.8)	
Tumour grade: n (%)							
Grade 1	77 (4.9)	23 (5.7)		4 (4.2)	88 (5.0)	8 (6.8)	
Grade 2	603 (38.5)	155 (38.2)	0.74[b]	35 (36.5)	681 (38.7)	42 (35.6)	0.72[b]
Grade 3	883 (56.3)	228 (56.2)		57 (59.4)	986 (56.0)	68 (57.6)	
Unknown	5 (0.3)	0 (0.0)		0 (0.0)	5 (0.3)	0 (0.0)	
Tumour size (cm): n (%)							
≤2	578 (36.9)	147 (36.2)		25 (26.0)	659 (37.4)	41 (34.8)	
>2 and ≤5	857 (54.7)	220 (54.2)	0.59[b]	61 (63.5)	952 (54.1)	64 (54.2)	0.38[b]
>5	132 (8.4)	39 (9.6)		10 (10.4)	148 (8.4)	13 (11.0)	
Unknown	1 (0.1)	0 (0.0)		0 (0.0)	1 (0.1)	0 (0.0)	
ER & HER2 status: n (%)							
ER+	1107 (70.6)	289 (71.2)		69 (71.9)	1248 (70.9)	79 (67.0)	
& HER2+	198 (12.6)	49 (12.1)		13 (13.5)	220 (12.5)	14 (11.9)	
& HER2-	772 (49.2)	201 (49.5)	0.85[c] (ER)	46 (47.9)	873 (49.6)	54 (45.8)	0.62[c] (ER)
& HER2 unknown	137 (8.7)	39 (9.6)	0.45[c] (HER2)	10 (10.4)	155 (8.8)	11 (9.3)	0.84[c] (HER2)
ER-	461 (29.4)	117 (28.8)		27 (28.1)	512 (29.1)	39 (33.1)	
& HER2+	118 (7.5)	43 (10.6)		8 (8.3)	141 (8.0)	12 (10.2)	
& HER2-	289 (18.4)	61 (15.0)		15 (15.6)	313 (17.8)	22 (18.6)	

	TPOAb- N = 1568	TPOAb+ N = 406	P value	Hypothyroid N = 96	Euthyroid N = 1760	Hyperthyroid N = 118	P value
& HER2 unknown	54 (3.4)	13 (3.2)		4 (4.2)	58 (3.3)	5 (4.2)	
Molecular subgroup: n (%)							
ER+/HER2-[1]	784 (50.0)	203 (50.0)	0.40[c]	47 (49.0)	885 (50.3)	55 (46.6)	0.94[c]
HER2+	316 (20.2)	92 (22.7)		21 (21.9)	361 (20.5)	26 (22.0)	
Triple negative	277 (17.7)	59 (14.5)		14 (14.6)	301 (17.1)	21 (17.8)	

Table 2: Multivariable analysis for disease-free survival by dichotomized autoantibodies to thyroid peroxidase (TPOAb)

		HR	95% CI	P value
TPOAb status	negative (n=1568)	1.00	-	-
	positive (n=406)	1.00	0.81-1.24	0.98
Nodal status	positive (n=1567)	1.00	-	-
	negative (n=407)	0.49	0.37-0.64	< 0.001
HER2 status	negative (n=1323)	1.00	-	-
	positive (n=408)	1.19	0.97-1.46	0.09
	unknown (n=243)	0.93	0.71-1.23	0.63
Age group (years)	<40 (n=306)	1.00	-	-
	40-49 (n=726)	0.78	0.61-1.00	0.05
	50-59 (n=757)	0.75	0.59-0.96	0.02
	≥60 (n=185)	0.95	0.69-1.31	0.76
Tumour grade	Grade 1 (n=100)	1.00	-	-
	Grade 2 (n=758)	1.15	0.74-1.78	0.55
	Grade 3 (n=1111)	1.39	0.89-2.17	0.14
	unknown (n=5)	0.77	0.10-5.75	0.80
Tumour size (cm) *	≤2 (n=725)	1.00	-	-
	>2 and ≤5 (n=1077)	1.37	1.12-1.66	0.002
	>5 (n=171)	1.88	1.41-2.52	< 0.001
Type of surgery	Mastectomy (n=1079)	1.00	-	-
	WLE (n=895)	0.79	0.66-0.95	0.01

HER2, human epidermal growth factor receptor-2; HR, hazard ratio (HR <1 indicates a favorable breast cancer outcome); WLE, wide local excision; 95% CI, 95% confidence interval.
* The patient with unknown tumour size (n=1) has not been considered for this analysis.

Supplemental Table 1: Baseline characteristics, treatments for breast cancer and disease-free survival (DFS) related characteristics

	Analysis population N = 1974	Not included patients N = 2188	All TACT trial patients N = 4162
Age (years), mean (SD)	49.1 (8.4)	48.2 (8.6)	48.6 (8.5)
Age group (years), n (%)			
<40	306 (15.5)	412 (18.8)	718 (17.3)
40-49	726 (36.8)	841 (38.4)	1567 (37.7)
50-59	757 (38.4)	730 (33.4)	1487 (35.7)
≥60	185 (9.4)	205 (9.4)	390 (9.4)
Nodal status, n (%)			
Node negative	407 (20.6)	428 (19.6)	835 (20.1)
1-3 positive nodes	890 (45.1)	949 (43.4)	1839 (44.2)
≥4 positive nodes	677 (34.3)	811 (37.1)	1488 (35.8)
Tumor grade, n (%)			
Grade 1	100 (5.1)	129 (5.9)	229 (5.5)
Grade 2	758 (38.4)	778 (35.6)	1536 (36.9)
Grade 3	1111 (56.3)	1271 (58.1)	2382 (57.2)
Unknown	5 (0.3)	10 (0.5)	15 (0.4)
Tumor size (cm), n (%)			
≤2	725 (36.7)	711 (32.5)	1436 (34.5)
>2 and ≤5	1077 (54.6)	1253 (57.3)	2330 (56.0)
>5	171 (8.7)	221 (10.1)	392 (9.4)
Unknown	1 (0.1)	3 (0.1)	4 (0.1)
ER & HER2 status, n (%)			
ER+	1396 (70.7)	1479 (67.6)	2875 (69.1)
& HER2+	247 (12.5)	247 (11.3)	494 (11.9)
& HER2-	973 (49.3)	990 (45.2)	1963 (47.2)
& HER2 unknown	176 (8.9)	242 (11.1)	418 (10.0)
ER-	578 (29.3)	709 (32.4)	1287 (30.9)
& HER2+	161 (8.2)	194 (8.9)	355 (8.5)
& HER2-	350 (17.7)	411 (18.8)	761 (18.3)
& HER2 unknown	67 (3.4)	104 (4.8)	171 (4.1)
Molecular subgroup, n (%)			
ER+/HER2-*	987 (50.0)	1014 (46.3)	2001 (48.1)
HER2+	408 (20.7)	441 (20.2)	849 (20.4)
Triple negative	336 (17.0)	387 (17.7)	723 (17.4)
Type of surgery and radiotherapy, n (%)			
Mastectomy	1079 (54.7)	1186 (54.2)	2265 (54.4)
with radiotherapy	865 (43.8)	949 (43.4)	1814 (43.6)
breast	159 (8.1)	254 (11.6)	413 (9.9)
chest wall	709 (35.9)	693 (31.7)	1402 (33.7)
supraclavicular fossa	480 (24.3)	500 (22.9)	980 (23.5)
axilla	85 (4.3)	103 (4.7)	188 (4.5)
Wide local excision	895 (45.3)	1002 (45.8)	1897 (45.6)
with radiotherapy	880 (44.6)	961 (43.9)	1841 (44.2)
breast	856 (43.4)	921 (42.1)	1777 (42.7)
chest wall	31 (1.6)	47 (2.1)	78 (1.9)
supraclavicular fossa	291 (14.7)	283 (12.9)	574 (13.8)
axilla	103 (5.2)	70 (3.2)	173 (4.2)
Endocrine treatment in ER+ patients, n (%)			
Tamoxifen monotherapy	863 (61.8)	927 (62.7)	1790 (62.3)
Tamoxifen followed by AI	454 (32.5)	439 (29.7)	893 (31.1)
AI monotherapy	61 (4.4)	76 (5.1)	137 (4.8)
No endocrine treatment/unknown	18 (1.3)	37 (2.5)	55 (1.9)

	Analysis population N = 1974	Not included patients N = 2188	All TACT trial patients N = 4162
Trastuzumab in HER2+ patients, n (%)			
Yes	48 (11.8)	28 (6.4)	76 (9.0)
No/Not known	360 (88.2)	413 (93.7)	773 (91.0)
Chemotherapy, n (%)			
Control (FEC)	626 (31.7)	639 (29.2)	1265 (30.4)
Control (E-CMF)	332 (16.8)	492 (22.5)	824 (19.8)
FEC-D	1016 (51.5)	1057 (48.3)	2073 (49.5)
Number of patients with event contributing to DFS analysis	**551 (27.9)**	**778 (35.6)**	**1329 (31.9)**
Local recurrence	76 (3.8)	107 (4.9)	183 (4.4)
Distant recurrence	405 (20.5)	572 (26.1)	977 (23.5)
New breast disease	43 (2.2)	44 (2.0)	91 (2.2)
Death from other cause (no recurrence)	27 (1.4)	51 (2.3)	78 (1.9)
Distant relapse ever reported	**462 (23.4)**	**655 (29.9)**	**1117 (26.8)**
New breast disease ever reported	**57 (2.9)**	**67 (3.1)**	**124 (3.0)**
All non-breast cancer second primary	**52 (2.6)**	**54 (2.5)**	**106 (2.5)**
All deaths	**397 (20.1)**	**620 (28.3)**	**1017 (24.4)**
Breast cancer	369 (18.7)	568 (26.0)	937 (22.5)
Death from other causes	28 (1.4)	52 (2.4)	80 (1.9)
Cancer (non-breast)	15 (0.8)	21 (1.0)	36 (0.9)
Treatment toxicity	0	5 (0.2)	5 (0.1)
Other	13 (0.7)	26 (1.2)	39 (0.9)

* includes ER-, PgR+, HER2-

AI, aromatase-inhibitors; ER+, positive estrogen receptor (ER); ER-, negative ER; E-CMF, epirubicin 100 mg/m^2 for 4 cycles followed by CMF (cyclophosphamide 600 mg/m^2, methotrexate 40 mg/m^2 and fluorouracil 600 mg/m^2) for 4 cycles; FEC, fluorouracil 600 mg/m^2, epirubicin 60 mg/m^2 and cyclophosphamide 600 mg/m^2 for 8 cycles; FEC-D, FEC for 4 cycles followed by docetaxel 100 mg/m^2 for 4 cycles; HER2+, positive human epidermal growth factor receptor-2 (HER2); HER2-, negative HER2; PgR+, positive progesterone receptor (PgR); SD, standard deviation; TACT, "Taxotere as adjuvant chemotherapy trial"; TPOAb, autoantibodies to thyroid peroxidase.

Supplemental Table 2: Events contributing to disease-free survival (DFS) and numbers of deaths by dichotomized TPOAb status

	TPOAb- (N = 1568) n (%)	TPOAb+ (N = 406) n (%)
Number of patients with event contributing to DFS analysis	**442 (28.2)**	**109 (26.8)**
Local recurrence	59 (3.8)	17 (4.2)
Distant recurrence	327 (20.9)	78 (19.2)
New breast disease	33 (2.1)	10 (2.5)
Death from other cause (no recurrence)	23 (1.5)	4 (1.0)
All deaths	**325 (20.7)**	**72 (17.7)**
Breast cancer	301 (19.2)	68 (16.7)
Death from other causes (without distant recurrence)	24 (1.5)	4 (1.0)
Cancer (non-breast)	14 (0.9)	1 (0.2)
Treatment toxicity	0 (0.0)	0 (0.0)
Other	9 (0.6)	3 (0.7)
Vascular (cardiac)	1 (0.1)	1 (0.2)
Vascular (cerebral)	1 (0.1)	0 (0.0)
Vascular (thromboembolic)	0 (0.0)	0 (0.0)
Respiratory	0 (0.0)	0 (0.0)
Accident, suicide, alcoholism	5 (0.3)	0 (0.0)
Infection (not treatment related)	0 (0.0)	1 (0.2)
Gastrointestinal bleed	0 (0.0)	0 (0.0)
Chronic liver disease	1 (0.1)	0 (0.0)
Unknown	2 (0.1)	1 (0.2)

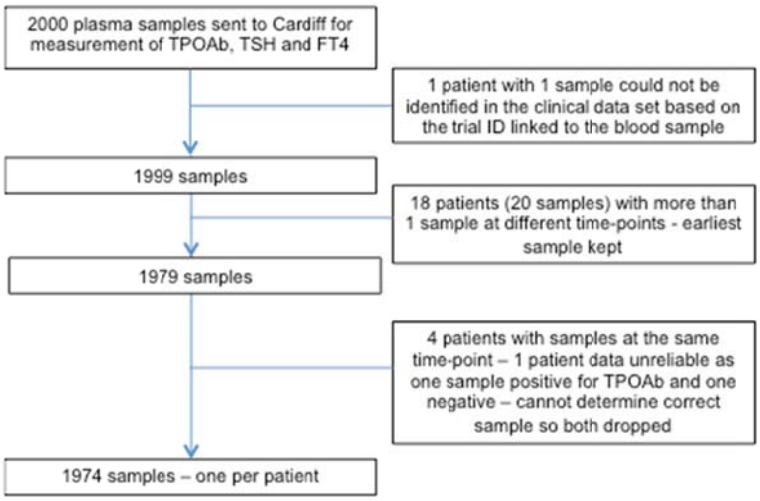
TPOAb+, positive autoantibodies to thyroid peroxidase (TPOAb); TPOAb-, negative TPOAb.

Supplemental Table 3: Univariate analyses for disease-free survival by FT4 and TSH

Variable		Unadjusted HR	95% CI	P value
FT4	Continuous	1.00	0.96-1.04	0.91
	<9.0 pmol/L (Hypothyroid; n=13)	1.61	0.67-3.88	0.29
	9.0–19.1 pmol/L (Euthyroid; n=1917)	1.00	-	-
	>19.1 pmol/L (Hyperthyroid; n=44)	1.08	0.62-1.87	0.79
TSH*	Continuous	1.03	0.94-1.13	0.48
	>4.40 mIU/L (Hypothyroid; n=94)	1.08	0.73-1.59	0.71
	0.3–-4.40 mIU/L (Euthyroid; n=1781)	1.00	-	-
	<0.3 mIU/L (Hyperthyroid; n=96)	1.19	0.82-1.72	0.36

FT4, free-thyroxine; HR, hazard ratio (HR <1 indicates a favorable breast cancer outcome); TSH, thyrotropin; 95% CI, 95% confidence interval.
*TSH value was available in 1971/1974 (99.8%) samples

Supplemental Fig. 1: Flowchart regarding sample availability and data handling



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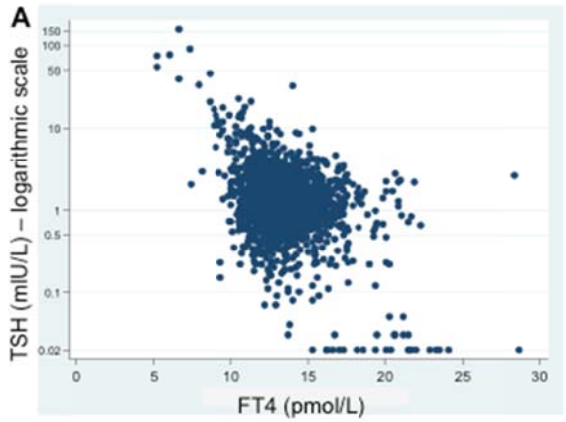
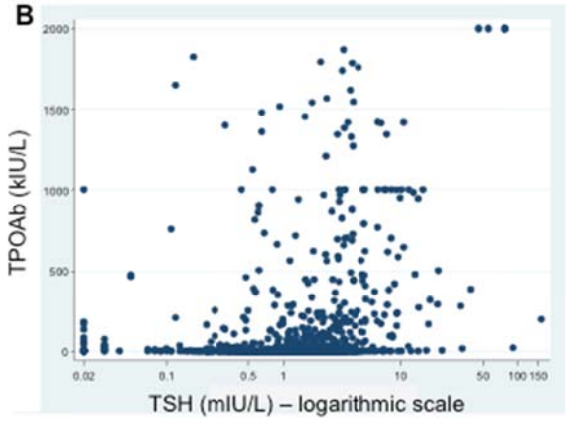
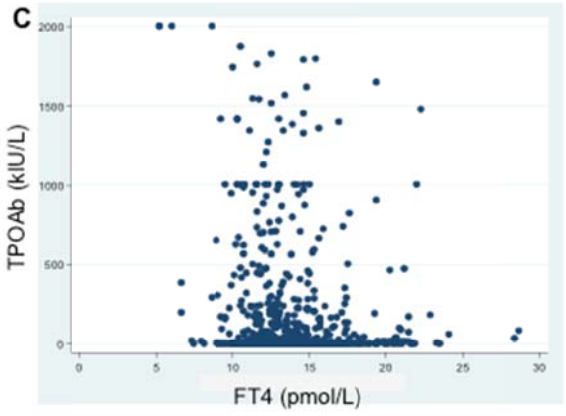
Supplemental Fig. 2: Correlation between thyroid markers



Spearman rank rho, -0.23; $P < 0.001$



Spearman rank rho, 0.24; $P < 0.001$



Spearman rank rho, -0.04; $P = 0.09$

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