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ORIGINAL RESEARCH

# RETRACTED ARTICLE: MYO5A inhibition by miR-145 acts as a predictive marker of occult neck lymph node metastasis in human laryngeal squamous cell carcinoma

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**Introduction:** Each year, ~50,000 patients worldwide die of laryngeal squamous cell carcinoma (LSCC) because of its highly metastatic property. However, its pathogenic mechanisms are still unclear, and in particular, the prediction of metastasis remains inconclusive. This study aimed to define the role of microRNA-145 (miR-145) in LSCC progression. We also aimed to elucidate the clinical significance of the miR-145/MYO5A pathway, especially the predictive function of MYO5A in neck lymph node metastasis.

**Materials and methods:** MYO5A and miR-145 expression was analyzed in 132 patients with LSCC, and association between their expression and clinicopathological features were evaluated. We validated the regulatory relationship between miR-145b and MYO5A by dual luciferase reporter assay. The role of the miR-145/MYO5A pathway in proliferation, metastasis, and apoptosis was examined in vitro. The predictive functions of MYO5A in neck lymph node metastasis and prognosis were confirmed according to patient follow-up.

**Results:** Our results showed downregulation of miR-145 in LSCC, which was negatively correlated with MYO5A suppression of LSCC progression and metastasis. MiR-145 directly regulated MYO5A expression in vitro and suppressed LSCC proliferation and invasion while promoting apoptosis by inhibiting MYO5A.

**Conclusion:** Notably, overexpression of serum MYO5A in LSCC predicted cervical nodal occult metastasis and poor prognosis, providing an effective indicator for predicting neck lymph node metastasis and assessing LSCC prognosis.

**Keywords:** laryngeal squamous cell carcinoma, miR-145, MYO5A, laryngeal cancer

## Introduction

Laryngeal carcinoma is one of the most common carcinomas of the head and neck. Its occurrence ranks third among head and neck malignancies, accounting for 3.1%–8.1% of these cancers.[1] Laryngeal squamous cell carcinoma (LSCC) accounts for more than 90% of laryngeal carcinomas.[2] Established treatments such as radiation, chemotherapy, and surgery can have little effect on advanced cases.[3–6] Owing to its aggressive nature and the limitations of early neck lymph node metastasis detection methods, there has not been significant improvement in the 5-year survival rate of patients with LSCC over the past 20 years.[7] Poor prognosis is usually associated with cervical nodal occult metastasis, which cannot be detected by clinical examination before treatment. Therefore, it is necessary to identify suppressive and predictive biomarkers for cervical nodal occult metastasis to improve the diagnosis and treatment of patients with LSCC.

MicroRNA-145 (miR-145) was first identified in the heart tissue of mice and later reported in humans.[8,9] MiR-145 is located within a 4.09 kb region on

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human chromosome 5 (5q32–33). It negatively regulates gene expression posttranscriptionally by binding to sites in the 3′ untranslated region (UTR) of target mRNAs.[10] It is among the most downregulated miRNAs in a variety of cancers, including bladder cancer,[11,12] breast cancer,[13,14] colon cancer,[9,15] colorectal cancer,[16–19] gastric cancer,[20] hepatocellular carcinoma,[21,22] lung cancer,[23,24] nasopharyngeal carcinoma,[25] oral cancer,[26] ovarian cancer,[27,28] pituitary tumors,[29] and prostate cancer.[30] MiR-145 has a strong inhibitory effect on cancer cell proliferation and is considered a tumor suppressor. It also suppresses the nodal metastasis of various solid malignancies, including cervical small-cell carcinoma, hepatocellular carcinoma, and colorectal carcinoma.[31–33] The effects of miR-145 on LSCC development and metastasis remain unknown.

A target gene predictive assay was performed using online target prediction tools (TargetScan, miRWalk, and PicTar). The genes predicted by all the software were considered as potential candidates. Combined with previous research, MYO5A may be a candidate target gene of miR-145. Class V myosins-like MYO5A are actin-dependent motor proteins that are primarily involved in the intracellular transport of organelles.[34] Early studies of MYO5A focused on its roles in neuron formation and function and neurological disease.[35–41] MYO5A also plays an important role in malignant melanoma.[42–45] Lan et al implicated MYO5A in cancer metastasis, and showed that MYO5A expression was increased in a number of highly metastatic cancer cell lines and metastatic colorectal cancer tissues.[46] Mendez et al revealed that expression of MYO5A is associated with neck lymph node metastasis of oral squamous cell carcinoma and, in combination with three other genes, is a better predictive marker of neck lymph node metastasis than primary tumor size.[47] Recently, Dynoodt et al observed decreased MYO5A mRNA and protein in miR-145 overexpressing melanoma cells.[48] However, the functions and clinical significance of MYO5A in LSCC neck lymph node metastasis are still unknown.

In this study, we demonstrate that miR-145 suppresses human LSCC progression and metastasis by inhibiting MYO5A, and that the serum MYO5A level may be an effective predictor of neck lymph node metastasis and patient prognosis.

# Materials and methods

## Study subjects and patient tissue samples

A total of 132 patients with LSCC who underwent total laryngectomy at Shengjing Hospital were included in this study (Table S1). Fresh tissue and blood samples were prospectively collected. Normal laryngeal mucosa tissue samples were collected from 57 of the 132 patients. Written informed consent was obtained from all participants, and the Ethics Committee of Shengjing Hospital approved the study (2014PS17K). Overall survival (OS) time was defined as the interval between the date of surgery and the date of death or last follow-up. Patient follow-up was maintained until either death or the cutoff date (November 2016). Clinicopathological data were obtained before initial treatment. Outcomes were tracked by telephone or from outpatient care records.

## Enzyme-linked immunosorbent assay (ELISA)

A commercial ELISA kit (MyBioSource, San Diego, CA, USA) was used to survey serum MYO5A levels according to the manufacturer's instructions. Fasting venous blood (1 mL) was extracted and centrifuged to isolate serum, which was stored at −80°C. Anti-MYO5A antibody (Thermo Fisher Scientific, Waltham, MA, USA) was used to coat 96-well plates overnight at 4°C. Serum samples and reconstituted standards (100 µL) were loaded in duplicate and incubated at 37°C for 2 h. After three washes, the wells were subsequently incubated with Detection Reagent A for 1 h at room temperature. After seven washes, the wells were incubated with Detection Reagent B (horseradish peroxidase-conjugated avidin) for 60 min at room temperature. Antigen-antibody complexes were revealed by adding 3,3′,5,5′-tetramethylbenzidine and measuring the absorbance at 450 nm.

## Quantitative real-time PCR analysis

Total miRNAs were isolated from fresh tissues and cells using the mirVanaTM miRNA Isolation kit (Thermo Fisher) according to the manufacturer's instructions. After cDNA synthesis, miR-145 expression levels were analyzed using the mirVanaTM miRNA Isolation kit (Thermo Fisher) and run on a 7300 real-time PCR system (Thermo Fisher). Reaction conditions included an initial 2 min incubation at 95°C, then 40 cycles at 95°C for 8 s, and 60°C for 40 s. Data were analyzed by the $2^{-\Delta\Delta CT}$ method. The average value of the control group was set to 1, and all relative values were multiplied by 10. The primer sequences used are listed in Box 1.[49]

## Western blot analysis

Total proteins were extracted from Hep-2 cells and tissues and quantitated by the Bradford method. The proteins were separated by sodium dodecyl sulfate-polyacrylamide gel electrophoresis on 8% gels and transferred to polyvinylidene difluoride membranes. The membranes were blocked with

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**Box 1** The primer sequences of Q-PCR

| | |
|---|---|
| *U6* | RT:CGACTCGATCCAGTCTCAGGGTCCGAGGT ATTCGATCGAGTCGCACTTTTTTTTTTTTV<br>Forward: 5′-CTCGCTTCGGCAGCACA-3′<br>Reverse: 5′-AACGCTTCACGAATTTGCGT-3′ |
| *miR-145* | RT:CGACTCGATCCAGTCTCAGGGTCCGAGGT ATTCGATCGAGTCGCACTTTTTTTTTTTTV<br>Forward: 3′-TCCCTAAGGACCCTTTTGACC-5′<br>Reverse: 5′-AGTCTCAGGGTCCGAGGTATTC-3′ |

5% skim milk for 1 h at room temperature, incubated with primary antibodies overnight at 4°C, washed with tris-buffered saline containing 0.5‰ TWEEN 20 (TBST) three times, incubated with secondary antibodies for 2 h at room temperature, and washed with TBST three times. Primary antibodies for MYO5A (1:1,000) and β-actin (1:2,000) were obtained from Thermo Fisher. Proteins were visualized by enhanced chemiluminescence and imaged with a UVP Image System (BD Biosciences, San Jose, CA, USA). The densities of protein bands were determined using ImageJ software (BD Biosciences). The levels of MYO5A protein were expressed as (MYO5A protein grey scale value/β-actin value) ×100.

## Cell culture and transient transfection

Human laryngeal carcinoma Hep-2 cells and TU177 cells (from the Shanghai Cell Bank of the Chinese Academy of Sciences, China) were maintained in a complete Roswell Park Memorial Institute (RPMI)-1640 medium containing 10% fetal bovine serum (FBS), L-glutamine (2 mmol/L), salt pyruvate (1 mmol/L), 1% nonessential amino acids, and streptomycin (10 mg/L) at 37°C in a humidified atmosphere of 5% $CO_2$. Hep-2 cells ($3\times10^4$) were transfected with miR-145 mimic, MYO5A-specific siRNA, a MYO5A overexpression vector (Cyagen Biosciences Inc., Santa Clara, CA, USA), or their negative controls (NCs; Thermo Fisher) in 6-well plates using Lipofectamine® 2000 transfection reagent (Thermo Fisher). After 48 h of transfection, cells were harvested for further assays.

## Flow cytometry

Live Hep-2 cells ($10^6$ cells) were fixed and permeabilized (BD Biosciences) then stained with an anti-MYO5A antibody (Thermo Fisher) for 20–30 min on ice. Next, cells were incubated with phycoerythrin-conjugated secondary antibody (Thermo Fisher) for 30 min on ice. Flow cytometry was performed on an LSR II flow cytometer (BD Biosciences) and the results were analyzed with FlowJo software (BD Biosciences).

## Quantification of apoptotic cells

An Annexin-V Apoptosis kit (BD Biosciences) was used to determine the extent of apoptosis. Cells were collected and incubated with 7-aminoactinomycin D (7-AAd) and annexin-V antibody for 15 min at room temperature. Flow cytometry was performed on an LSR II flow cytometer (BD Biosciences) and analyzed with FlowJo software (BD Biosciences). Annexin V and 7-AAd double positive cells were considered apoptotic. Annexin V positive/7-AAd negative cells were considered to be in early apoptosis.

## Cell proliferation assays

Cells were treated with 10 μg/mL mitomycin for 2 h, and then their proliferation was evaluated by MTT assay (Sigma-Aldrich Co., St Louis, MO, USA). After transient transfection, cells were harvested and cultured in 96-well plates at 37°C in a humidified atmosphere with 5% $CO_2$ for 24, 48, 72, and 96 h. At each time interval, 5 mg/mL MTT was added to each well and the cells were incubated for 4 h. The blue formazan products formed were dissolved in dimethyl sulfoxide (100 μL) and spectrophotometrically measured at 490 nm.

## Cell migration and invasion assays

Cells were treated with 10 μL/mL mitomycin for 2 h before migration and invasion assays. Cell migration assays were performed in triplicate using Transwell migration chambers (8 μm pore size; Corning Incorporated, Corning, NY, USA). For invasion assays, wells were coated with diluted extracellular matrix (ECM) solution (Sigma-Aldrich Co.) as described in the manufacturer's protocol. After transfection, Hep-2 cells ($5\times10^4$) were transferred to the upper chamber or ECM gel in serum-free culture. RPMI-1640 containing 10% FBS was added to the lower chambers. After incubation at 37°C and 5% $CO_2$ for 24 h, cells that remained on top of the filter were removed and cells that migrated or invaded to the lower surface were fixed in 90% ethanol, stained with H&E, and counted by light microscopy.

## Colorimetric caspase-3 assays

Hep-2 and TU177 cells were lysed, and their protein concentrations were determined. Proteins (100 μg) were treated with 10 μL of Ac-DEVD-pNA (Abcam, Cambridge, MA, USA) and incubated for 2 h at 37°C. The absorbance at 405 nm was measured using a microplate reader (Bio-Tek Instruments Inc., Winooski, VT, USA).

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## Luciferase reporter assays

The 3′-UTR region of human *MYO5A* was cloned into the pGL3 luciferase reporter plasmid (Promega Corporation, Fitchburg, WI, USA). Wild type and mutated *MYO5A* 3′ UTR luciferase reporter vectors were cotransfected into Hep-2 cells with miR-145 mimic or an NC using Lipofectamine 2000™ (Thermo Fisher).[50] Cells were harvested 48 h after transfection. Luciferase activities were analyzed using the Dual-Luciferase Reporter Assay System (Promega Corporations) according to the manufacturer's protocol.

## Patient follow-up

All patients were examined in our outpatient department every 3 months for the first 2 years after resection and semi-annually thereafter. Follow-up included history taking, cervical computed tomography (CT) scans, and laryngoscopy. Radionuclide bone scans, brain CT scan, and chest positron emission tomography-CT scans were conducted if clinically indicated. The survival time was defined as the interval between surgery and death or last follow-up. We defined 36 months as the minimum follow-up period for accepting a case as $N_0$.

## Statistical analysis

All experiments were repeated in triplicate. The data represent the mean±SD. All statistical analyses were performed using SPSS statistical software package (version 17; SPSS Inc., Chicago, IL, USA) Student's *t*-test was used to compare differences in miR-145 and MYO5A expression between LSCC and healthy mucosa tissues. Correlations between miR-145 expression, MYO5A expression, and clinicopathological parameters were also analyzed by *t*-test. The Pearson correlation test was used to analyze the relationship between miR-145 and MYO5A expression. A receiver operating characteristic (ROC) curve and its area under the curve (AUC) were introduced to evaluate the predictive value of serum MYO5A levels. The Kaplan–Meier method was used to compare patient survival. For all analyses, we considered *P*-values <0.05 to be significant.

# Results

## Downregulation of miR-145 in LSCC is negatively correlated with MYO5A expression

To investigate miR-145 expression in LSCC, quantitative real-time PCR was performed on 132 LSCC samples and 57 healthy laryngeal mucosa samples acquired from patients with LSCC who underwent total laryngectomy. MiR-145 expression significantly decreased in the LSCC group compared with that in the healthy mucosa group (4.05±2.82 vs 10.00±2.44, $P$=0.002; Figure 1A). MiR-145 expression decreased significantly in 49/57 LSCC tissues compared with that in paired healthy mucosa tissues ($P$<0.001; Figure 1B). Western blot was used to detected MYO5A expression in the 132 LSCC samples and 57 laryngeal normal mucosa samples (Figure 1C). The relative MYO5A expression value in LSCC tissue was 64.52±15.20, significantly higher than that in healthy tissue (31.81±8.30, $P$=0.007). MYO5A expression was also compared among the 57 paired LSCC and mucosa tissues (Figure 1D), and it increased significantly in 52/57 LSCC samples ($P$ < 0.001). The correlation between miR-145 and MYO5A levels in the LSCC and control samples was evaluated by Pearson correlation test. We found that miR-145 expression was negatively correlated with MYO5A expression (r=0.549, $P$=0.018; Figure 1E). These results suggest that the aberrant expression of miR-145 and MYO5A correlated in clinical LSCC samples.

## MiR-145 may suppress LSCC progression and metastasis in humans

To explore the clinical significance of the miR-145/MYO5A pathway in LSCC, we extracted clinicopathological parameters for the 132 patients from inpatient records. Age, sex, primary tumor site, T stage, tumor cell differentiation, and neck lymph node metastasis were analyzed for association with miR-145 and MYO5A levels (Tables 1 and 2). There were no significant differences in miR-145 and MYO5A levels with different ages, sexes, and primary tumor sites. Notably, miR-145 expression was significantly increased in early T stages and with good cell differentiation. In addition, patients suffering from neck lymph node metastasis (including neck lymph node metastasis and occult neck lymph node metastasis) displayed lower miR-145 expression. In contrast, MYO5A expression was suppressed significantly at early T stages but was unchanged by cell differentiation status. Furthermore, marked increases in MYO5A expression were observed in patients with neck lymph node metastasis. The relationship between miR-145 and MYO5A expression levels in tumors with perinodal versus lymphovascular and perineural invasion, as confirmed during surgery, were analyzed (Tables 1 and 2). Patients with perinodal invasion displayed higher MYO5A expression. Other differences were not statistically significant. Taken together, the results suggest that miR-145 may suppress LSCC progression and metastasis by regulating MYO5A expression.

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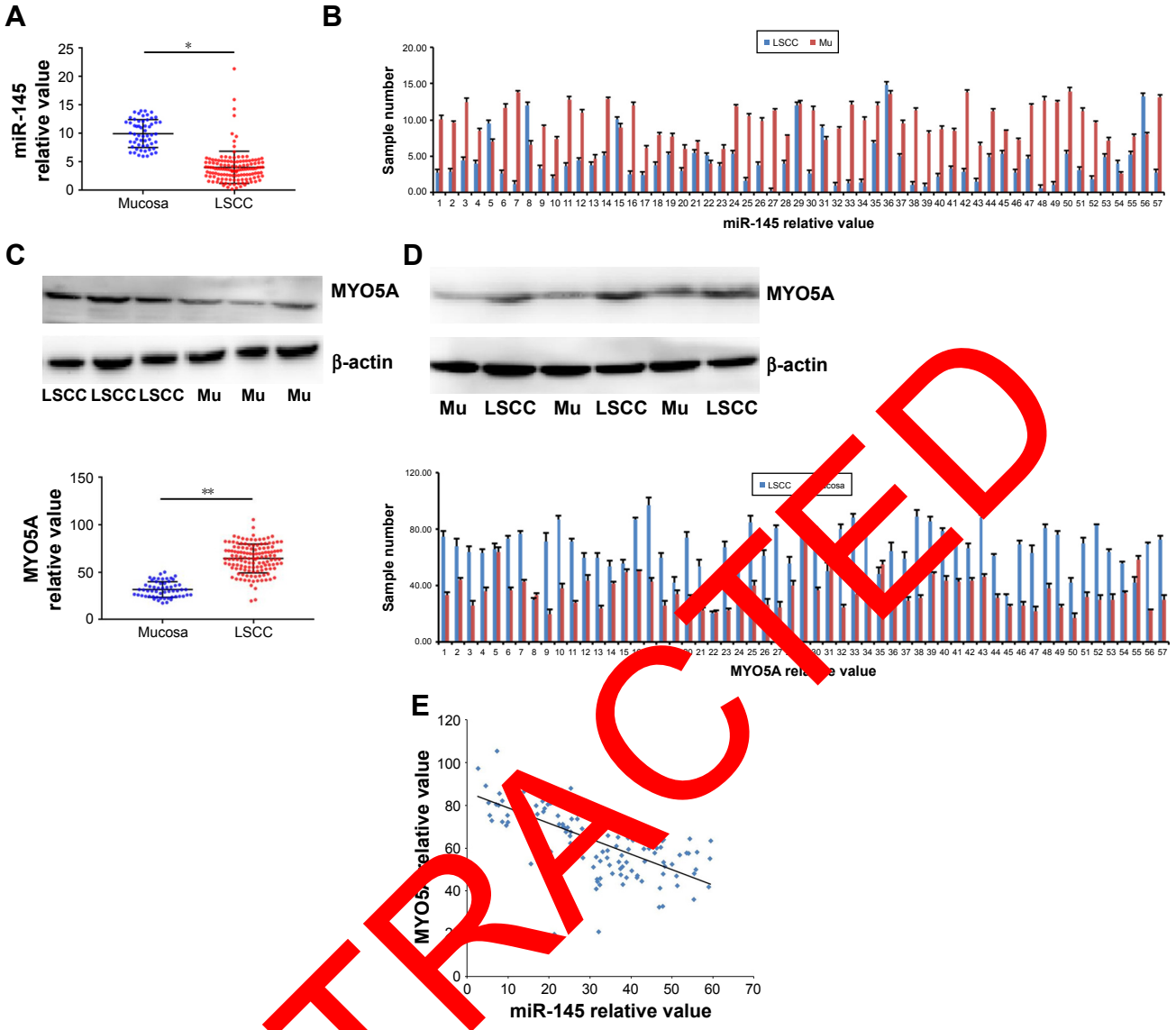


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**Figure 1** Downregulation of miR-145 in LSCC is negatively correlated with MYO5A expression (**A**). Quantitative real-time PCR was performed on 132 LSCC samples and 57 laryngeal healthy Mu acquired from patients with LSCC who underwent total laryngectomy. (**B**) MiR-145 expression in 57 paired LSCC and healthy Mu tissues. (**C**) Western blot was used to detected MYO5A expression differences between LSCC and healthy Mu. (**D**) MYO5A expression in 57 paired tissue samples. (**E**) The Pearson correlation test was used to analyze the relationship between miR-145 and MYO5A levels.

**Notes:** *$P<0.05$; **$P<0.01$.

**Abbreviations:** LSCC, laryngeal squamous cell carcinoma; Mu, mucosa; miR-145, microRNA-145.

## MiR-145 directly regulates MYO5A expression in Hep-2 cells

We predicted that MYO5A might be a miR-145 candidate target using online target predication tools (TargetScan, miRWalk, and PicTar). In addition, Dynoodt et al reported decreased MYO5A mRNA and protein in miR-145-overexpressing melanoma cells.[48] However, whether miR-145 regulates MYO5A remains unresolved. We transfected Hep-2 cells with miR-145 mimic or an NC and western blot was used to detect MYO5A expression (Figure 2A). MYO5A decreased significantly in Hep-2 cells transfected with miR-145 mimic (from 71.35±4.61 to 39.25±2.69, $P<0.001$) but was unaffected by the negative control (68.16±2.82). This suggests that MYO5A expression changed in correlation with miR-145 levels. Flow cytometry was used to detect the MYO5A mean fluorescence intensity (MFI) in Hep-2 cells transfected with miR-145 mimic. The MFI decreased significantly compared with that of the NC (Figure 2B). In contrast, there was no significant difference in the expression of nudix hydrolase 1 (NUDT1), a potential miR-145 target in Hep-2 cells, with changes in miR-145 expression ($P>0.05$; Figure 2C).

**Table 1** Correlation of miR-145 expression with the clinicopathological features of patients with LSCC

| Parameters | Patients n (%) | miR-145 level | *P*-value |
|---|---|---|---|
| Total | 132 | | |
| Sex | | | 0.408 |
| Male | 114 (86.4) | 4.14±2.98 | |
| Female | 18 (13.6) | 3.54±1.58 | |
| Age (years) | | | 0.343 |
| ≥60 | 84 (63.6) | 3.88±2.07 | |
| <60 | 48 (36.4) | 4.36±3.82 | |
| Primary site | | | 0.671 |
| Glottic | 76 (57.6) | 3.96±2.42 | |
| Supraglottic | 56 (42.4) | 4.18±3.32 | |
| T stage | | | 0.021 |
| $T_2$ | 51 (38.6) | 5.13±3.80 | |
| $T_3$ $T_4$ | 81 (61.4) | 3.38±1.69 | |
| Differentiation | | | 0.013 |
| High | 85 (64.4) | 4.68±3.19 | |
| Moderate and low | 47 (35.6) | 2.93±1.47 | |
| Neck lymph node metastasis | | | 0.005 |
| N+ | 61 (46.2) | 2.85±1.41 | |
| N– | 71 (53.8) | 5.09±3.31 | |
| Perinodal invasion | | | 0.588 |
| + | 21 (45.7) | 3.87±2.53 | |
| – | 25 (54.3) | 4.30±2.97 | |
| Lymphovascular and perineural invasion | | | 0.495 |
| + | 13 (28.3) | 3.73±3.01 | |
| – | 33 (71.7) | 4.28±2.85 | |

**Note:** The data is presented as mean ± SD.
**Abbreviations:** LSCC, laryngeal squamous cell carcinoma; miR-145, microRNA-145.

**Table 2** Correlation between MYO5A expression and the clinicopathological features of patients with LSCC

| Parameters | Patients n (%) | MYO5A level | *P*-value |
|---|---|---|---|
| Total | 132 | | |
| Sex | | | 0.883 |
| Male | 114 (86.4) | 64.60±15.22 | |
| Female | 18 (13.6) | 64.03±15.52 | |
| Age (years) | | | 0.864 |
| ≥60 | 84 (63.6) | 64.35±15.21 | |
| <60 | 48 (36.4) | 64.83±15.35 | |
| Primary site | | | 0.952 |
| Glottic | 76 (57.6) | 64 [illegible] | |
| Supraglottic | 56 (42.4) | [illegible]4.62±14.8[illegible] | |
| T stage | | | 0.003 |
| $T_2$ | 51 (38.6) | [illegible]60±14.40 | |
| $T_3$ $T_4$ | 81 (6[illegible]) | 67.[illegible]14.96 | |
| Differentiation | | | 0.713 |
| High | 8[illegible]64.4) | 64.78±14.95 | |
| Moderate and low | 47 (3[illegible]) | 6[illegible]±14.09 | |
| Neck lymph node [illegible]stasis | | | |
| N+ | 61 (46.2) | 73.02±12.39 | |
| N– | [illegible] (53.8) | 57.23±13.57 | |
| Perinod[illegible]invasion | | | 0.037 |
| + | 21 (45.7) | 69.23±18.81 | |
| – | 25 (54.3) | 60.17±16.79 | |
| Lymp[illegible]ascular and [illegible]rineural invasion | | | 0.274 |
| + | 13 (28.3) | 66.39±16.51 | |
| | 33 (71.7) | 63.11±15.88 | |

**N[illegible]:** The[illegible]a is presented as mean ± SD.
**[illegible]bbreviation:** LSCC, laryngeal squamous cell carcinoma.

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To confirm the regulatory relationship betw[illegible]n miR-[illegible]5 and MYO5A, we conducted luciferase repor[illegible] assay[illegible]uciferase reporters containing wild type or mu[illegible]d *MYO5A* [illegible]O5Auta were constructed (Figure 2D). The relative [illegible]ciferase activity of the reporter containing the wi[illegible]type *MYO5A* [illegible]UTR was significantly decreased with [illegible]R-145 [illegible]otransfection ($P<0.001$), whereas the activity o[illegible]e re[illegible]rter containing the mutant binding site was u[illegible]ffected ([illegible]ure 2E). These results strongly indicate that M[illegible]O5A [illegible]a direc[illegible]t of miR-145.

## MiR-145 [illegible]ppresses LSCC proliferation and invasion [illegible]nd promotes apoptosis by inhibiting MYO[illegible]A expression

The effects of miR-145/MYO5A levels on LSCC growth were examined by cell proliferation assay. Hep-2 cells were transiently transfected with miR-145 mimic and either MYO5A-specific siRNA or an NC siRNA. Hep-2 cells with overexpression of miR-145 or knockdown of MYO5A displayed time-dependent reductions in cell proliferation compared with the NCs (Figure 3A and B), indicating that miR-145 inhibits proliferation via MYO5A in vitro. MiR-145 overexpression decreased proliferation by [illegible]9.4%±3.5%, 29.7%±4.7%, 32.6%±3.1%, and 33.5%±4.5% after 24, 48, 72, and 96 h, respectively ($P=0.046$), whereas MYO5A siRNA decreased proliferation by 20.1%±1.6%, 28.1%±2.3%, 22.2%±1.7%, and 27.5%±2.7% after 24, 48, 72, and 96 h, respectively ($P=0.044$).

To determine the effects of miR-145/MYO5A levels on LSCC migration and invasion, we conducted Transwell migration and invasion assays. Overexpression of miR-145 or knockdown of MYO5A in Hep-2 cells resulted in reduced cell migration and invasion (Figure 3C and D). Annexin-V staining was used to examine the effects of miR-145/MYO5A on LSCC apoptosis. Overexpression of miR-145 significantly promoted Hep-2 cell apoptosis (Figure 3E), as did knockdown of MYO5A (Figure 3F). Similar results were observed by colorimetric caspase 3 assay (Figure 3G and H). Collectively, these data indicate that miR-145 suppresses LSCC proliferation and invasion and promotes apoptosis in vitro by inhibiting MYO5A.

## Forced MYO5A overexpression restores the inhibitory effects of miR-145

To further understand the MYO5A-mediated inhibitory effects of miR-145 in LSCC, we transfected an MYO5A

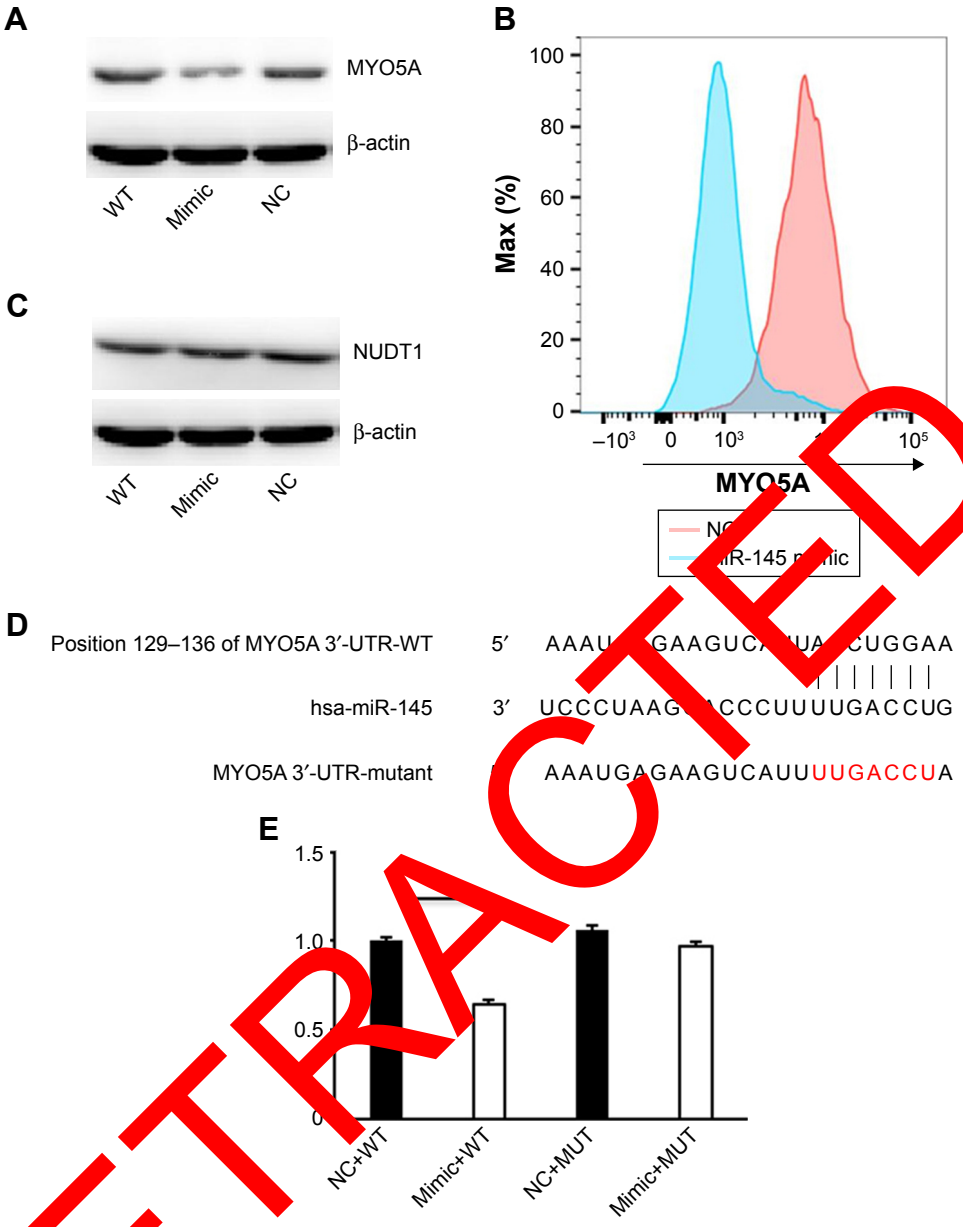


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**Figure 2** MiR-145 directly regulates MYO5A expression in Hep-2 cells. (**A**) Western blot analysis of MYO5A levels in Hep-2 after transfection of either miR-145 mimic or an NC. (**B**) Representative graph and MFI of MYO5A staining in Hep-2 cells. (**C**) NUDT1 expression in Hep-2 cells transfected with miR-145 mimic or an NC. (**D**) MiR-145 directly interacts with the 3′-UTR of MYO5A. (**E**) Luciferase reporter assays were performed 48 h after transfection with WT or MUT *MYO5A* 3′-UTR plasmids cotransfected with miR-145 mimic or NC.
**Note:** *P<0.001.
**Abbreviations:** NC, negative control; MFI, mean fluorescence intensity; WT, wild type; MUT, mutant; NUDT 1, nudix hydrolase 1; miR-145, microRNA-145.

overexpression vector into miR-145-overexpressing TU177 cells (Figure 4A) restoring MYO5A expression (69.71±5.77 vs 40.03±4.62 in cells transfected with mimic alone; $P$=0.031), and found that MYO5A overexpression released the suppressive effects of miR-145 on proliferation and invasion (Figure 4B and C). Compared with miR-145-overexpressing TU177 cells, a time-dependent increase in cell proliferation was observed in TU177 cells with MYO5A overexpression (6.8%±0.4%, 18.4%±2.7%, 22.0%±4.1%, and 30.3%±4.7% at 24, 48, 72, and 96 h, respectively, $P$<0.05). Moreover, MYO5A overexpression significantly inhibited apoptosis (Figure 4D and E). These finding suggest that miR-145 suppresses LSCC progression by inhibiting MYO5A.

## MYO5A overexpression in LSCC predicts cervical nodal occult metastasis

Cervical nodal occult metastasis is a form of neck lymph node metastasis that cannot be detected by clinical examination, including physical and radiological tests. Many $N_0$ stage patients who suffer from cervical nodal occult metastasis

do not receive proper treatment in time because of a lack of effective predictive indicators. To explore the utility of MYO5A levels in predicting cervical occult metastasis, western blot and ELISA were used to detect MYO5A expression in LSCC tissues and serum. We divided the 132 patients into 3 groups according to cervical metastatic state, $N^+$, $N_0^+$, and $N^-$, which contained 29, 32, and 71 patients, respectively. Patients with recognized neck lymph node metastasis before surgery were defined as $N^+$. The $N_0^+$ group included patients that were initially recognized as neck lymph node metastasis negative before surgery but were diagnosed with neck lymph node metastasis either during surgery or in later follow-up. The $N^-$ group included patients in which neck lymph node metastasis was not detected at any point in the process.

Western blot was used to detect MYO5A expression in 132 LSCC tissues. MYO5A increased significantly in the $N^+$ and $N_0^+$ groups compared with that in the $N^-$ group (74.69±10.63 vs 57.23±13.57, $P$=0.008; 71.50±13.79 vs 57.23±13.57, $P$=0.024; Figure 5A), whereas the $N^+$ and $N_0^+$ groups showed similar MYO5A expression (Figure 5B). These results revealed that MYO5A could be used as an indicator of neck lymph node metastasis, and suggest that the cervical treatment plan (cervical lymph node dissection or radiotherapy) for each patient could be determined according to preoperative assessment of MYO5A expression. However, in clinical practice, western blot is not typically used in presurgical bi[illegible]rker detection. To determine more easily MYO[illegible]A expre[illegible]ion before surgery, ELISA was used to dete[illegible]serum MYO[illegible]A levels. The serum concentrations [illegible] MYO[illegible] in the [illegible] and $N_0^+$ groups were significantl[illegible]igher th[illegible]n tho[illegible]i[illegible]the $N^-$ group (294.2±62.0 pg/mL [illegible]199.[illegible]±71.1 pg/mL, $P$=0.003;

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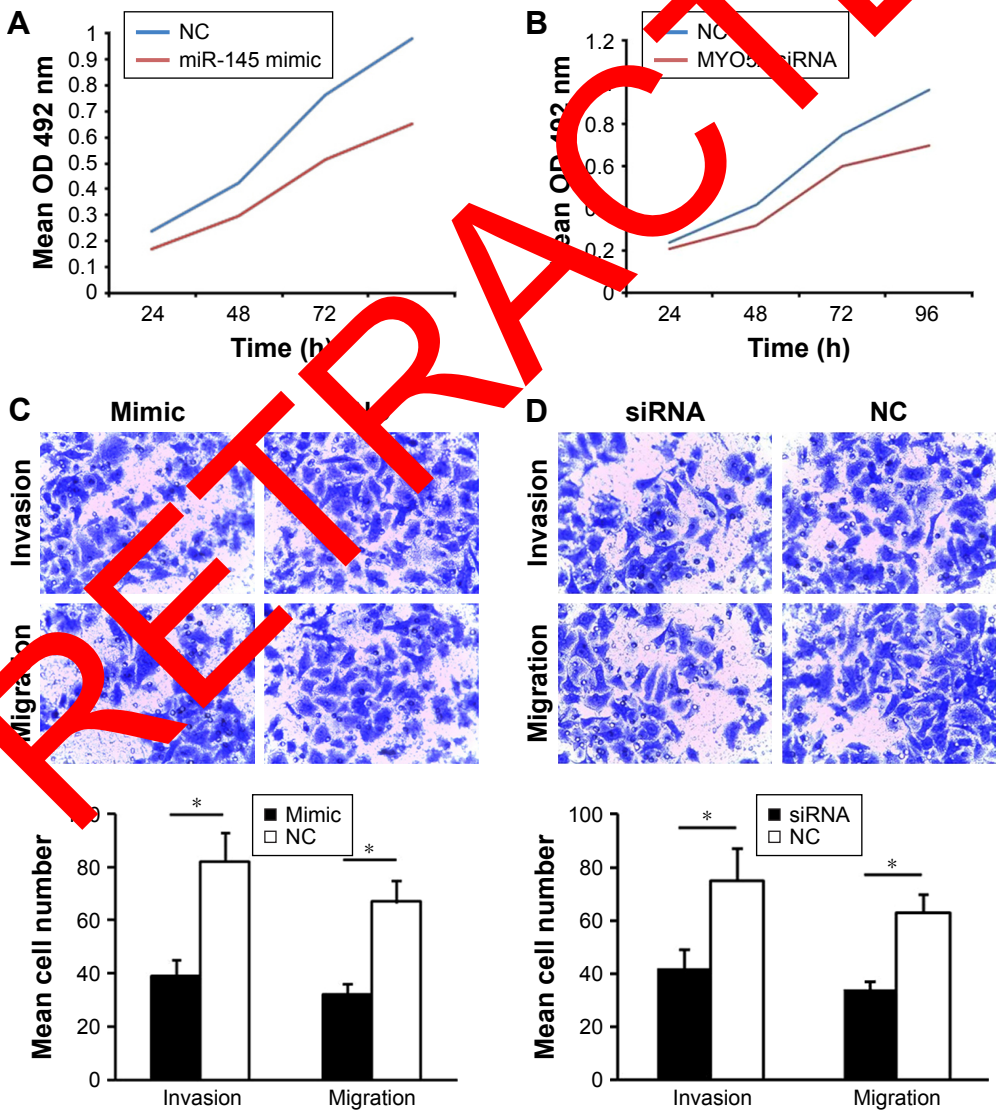


**Figure 3** (*Continued*)

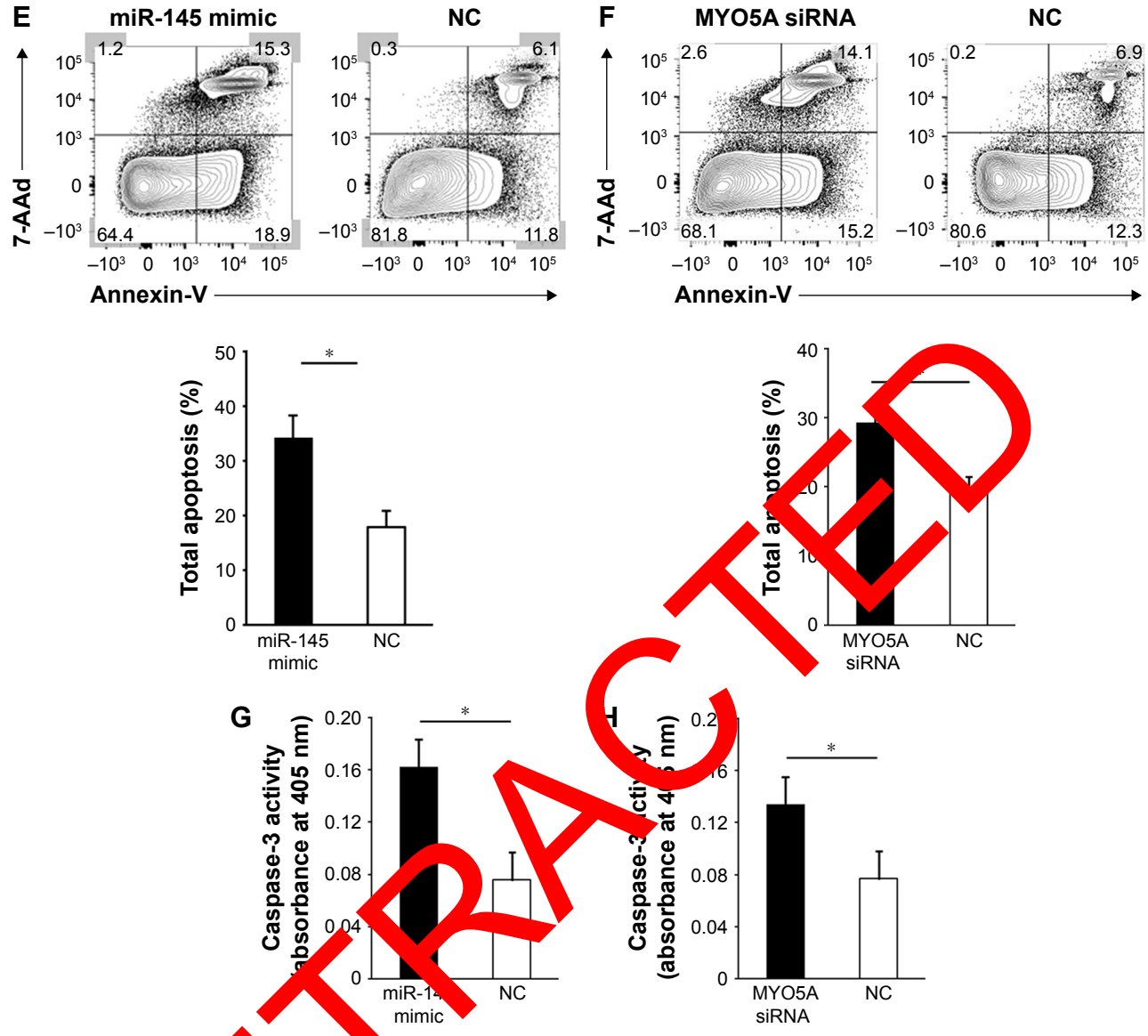


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**Figure 3** MiR-145 suppresses LSCC proliferation and invasion and promotes apoptosis by inhibiting MYO5A. (**A**) Proliferation rates of Hep-2 cells at various time points after transfection with either miR-145 mimic or an NC. (**B**) Proliferation rates of Hep-2 cells at various time points after transfection with either MYO5A siRNA or an NC. (**C**) Hep-2 cells were transiently transfected with miR-145 mimic or an NC and subjected to migration and invasion assays. Representative photographs and quantification are shown. Magnification: ×200. (**D**) Hep-2 cells were transiently transfected with MYO5A-specific or NC siRNA and subjected to migration and invasion assays. Representative photographs and quantification are shown. Magnification: ×200. (**E**) Representative graph of the percentage of Hep-2 cells in apoptosis after transfection with miR-145 mimic or an NC. (**F**) Representative graph of the percentage of Hep-2 cells in apoptosis after transfection with MYO5A-specific siRNA or an NC. (**G**) Caspase-3 activity in Hep-2 cells transfected with miR-145 mimic or an NC. (**H**) Caspase-3 activity in Hep-2 cells transfected with MYO5A-specific siRNA or an NC.
**Note:** *$P$<0.05.
**Abbreviations:** LSCC, laryngeal squamous cell carcinoma; NC, negative control; miR-145, microRNA-145; 7-AAd, 7-aminoactinomycin D; OD, optical density.

276.3±73.5 pg/mL vs 199.3±71.1 pg/mL, $P$=0.009; Figure 5C), with no significant differences between the $N^+$ and $N_0^+$ groups (Figure 5D). Taken together, these results suggest that MYO5A levels in both the primary tumor tissue and the serum increase significantly with neck lymph node or occult metastasis, indicating its promise as a presurgical biomarker.

An ROC curve was drawn to determine the best serum MYO5A concentration for neck lymph node metastasis prediction. The AUC was calculated to evaluate the diagnostic value of MYO5A expression. The AUC of serum MYO5A to predict neck lymph node metastasis was 0.823. The diagnostic sensitivity (77.8%) and specificity (75.4%) were highest when the cutoff value was 240.5 pg/mL, suggesting the best predictive performance at this level (Figure 5E). We conclude that MYO5A can be a powerful indicator for predicting neck lymph node metastasis, especially cervical occult metastasis, in clinical practice, enabling the planning of suitable therapies for neck lymph node metastasis-negative patients.

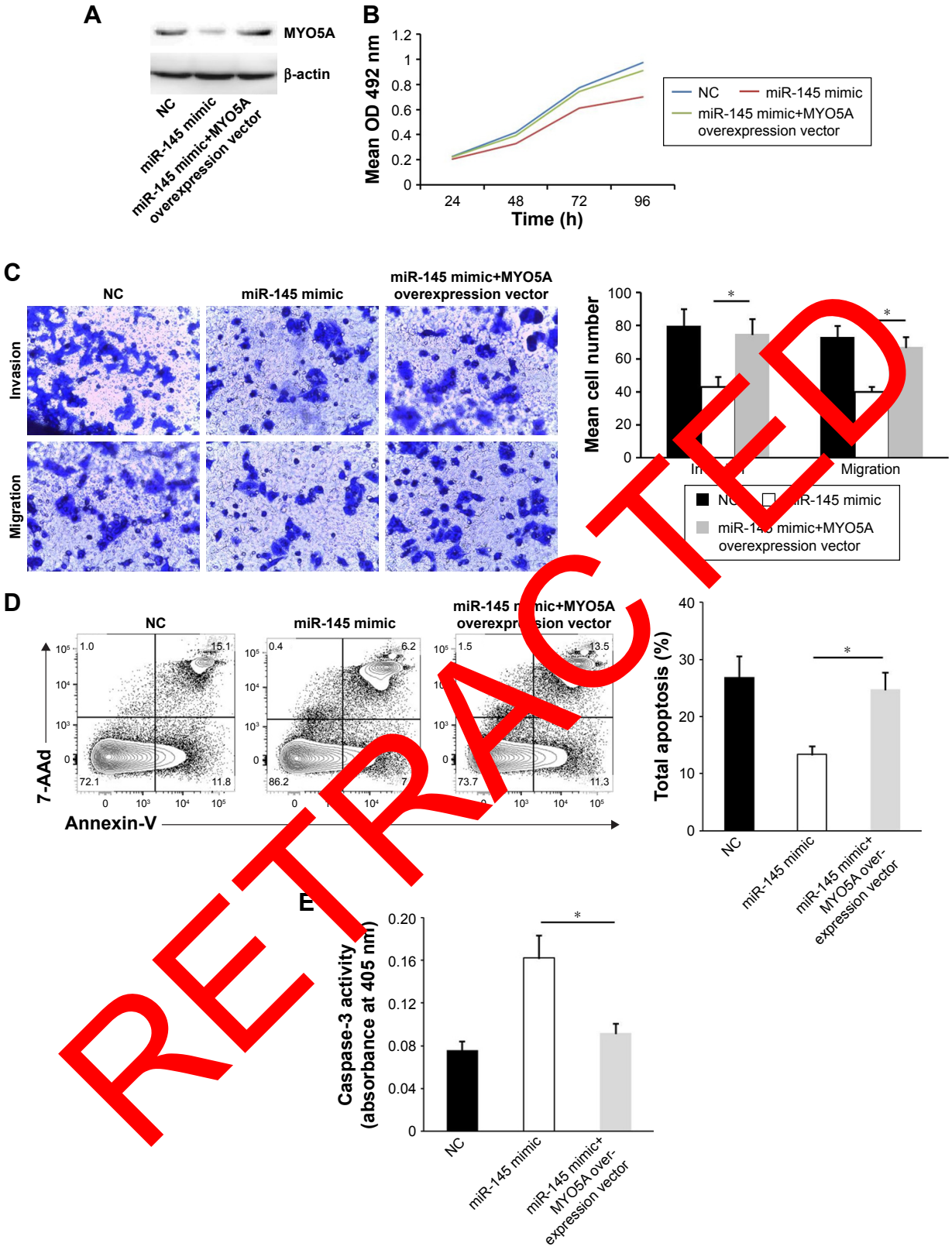


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**Figure 4** MYO5A overexpression restores the inhibitory effects of miR-145. (**A**) Representative Western blot showing the restoration of MYO5A expression after cotransfection of a miR-145 mimic and an MYO5A overexpression vector compared with cells transfected with miR-145 mimic alone. (**B**) Proliferation rates of miR-145-overexpressing TU177 cells at various time points after MYO5A overexpression. (**C**) Representative photographs (top; ×200 magnification) and quantitative analysis (bottom) of Transwell migration and invasion assays in TU177 cells transfected with miR-145 mimic with and without MYO5A overexpression. (**D**) Representative graph of the percentage of TU177 cells in apoptosis after transfection with miR-145 mimic with and without MYO5A overexpression. (**E**) Caspase-3 activity of TU177 cells transfected with miR-145 mimic with and without MYO5A overexpression.

**Note:** *$P<0.05$.

**Abbreviations:** LSCC, laryngeal squamous cell carcinoma; NC, negative control; miR-145, microRNA-145; OD, optical density.

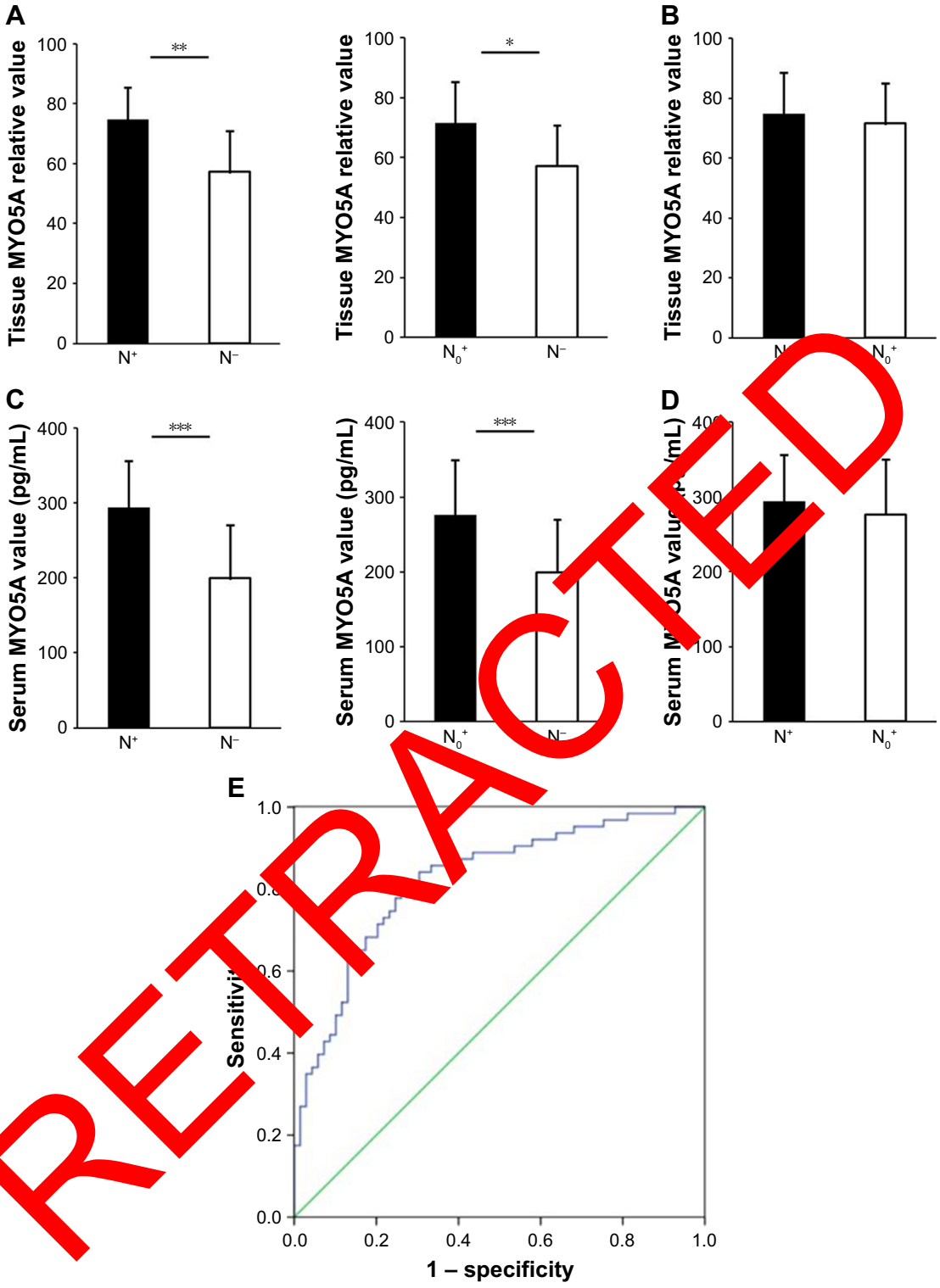


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**Figure 5** Overexpression of MYO5A in LSCC predicts cervical nodal occult metastasis (**A**, **B**) MYO5A protein levels in the $N^+$, $N_0^+$, and $N^-$ groups. (**C**, **D**) Serum MYO5A concentrations in the $N^+$, $N_0^+$, and $N^-$ groups. (**E**) ROC curve of the neck lymph node metastasis predictive value of MYO5A levels in patients with LSCC.
**Notes:** *$P<0.05$, **$P<0.01$, ***$P<0.001$.
**Abbreviations:** LSCC, laryngeal squamous cell carcinoma; ROC, receiver operating characteristic.

## MYO5A overexpression predicts poor prognosis

All 132 patients were followed-up at our outpatient clinic or by telephone. The mean follow-up time was 70 months (median: 72 months; range: 38–93 months). The 3- and 5-year OS rates were 77.27% and 71.21%, respectively. The patients were divided into 2 groups according to miR-145 or serum MYO5A levels. Patients with lower miR-145 levels (<4.05)

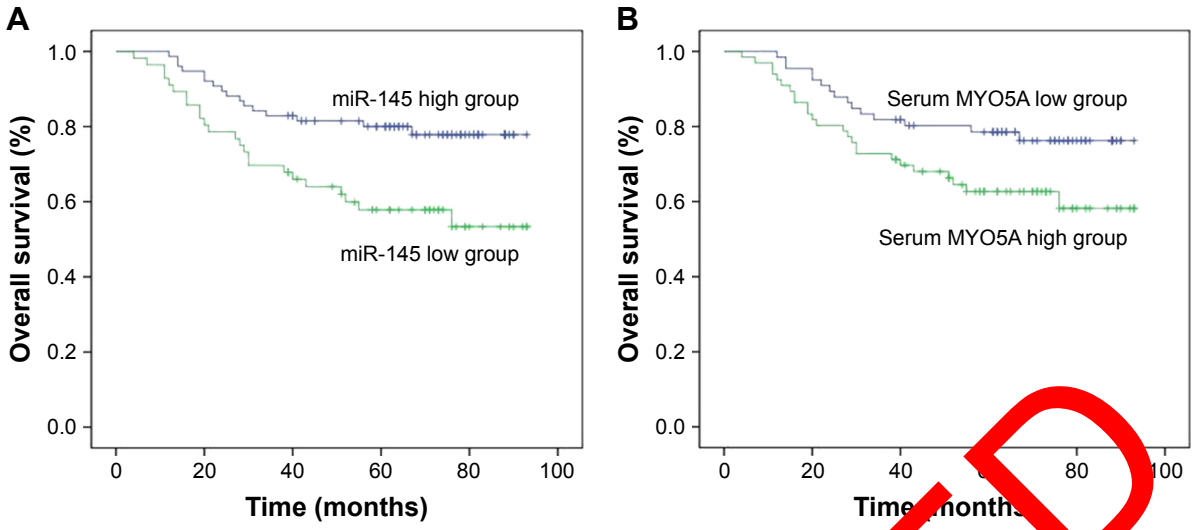


**Figure 6** Overexpression of MYO5A predicts poor prognosis (**A**) OS rates after 3 and 5 years with varying miR-145 levels. (**B**) OS rates after 3 and 5 years with varying serum MYO5A levels.
**Abbreviations:** miR-145, microRNA-145; OS, overall survival.

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had significantly poorer 3- and 5-year OS rates (69.64% vs 82.89% and 58.93% vs 80.2%, respectively, *P*=0.027; Figure 6A). Patients with higher serum MYO5A levels (>240.5 pg/mL) also had significantly poorer 3- and 5-year OS rates (72.31% vs 82.09% and 64.62% vs 77.61%, respectively, *P*=0.041; Figure 6B).

Next, univariate and multivariate analyses were conducted to determine potential prognostic factors. Only parameters that were significant in univariate analyses were further analyzed by multivariate analysis. Univariate analysis showed that differentiation (*P*=0.018), T stage (*P*=0.023), neck lymph node metastasis status (*P*=0.029), miR-145 level (*P*=0.041) and serum MYO5A level (*P*=0.021) had significant effects on OS (Table 3). Only the T stage (*P*=0.047), cervical state (*P*=0.029), and serum MYO5A level (*P*=0.038) were independent significant prognostic factors for OS in multivariate analysis (Table 3). This suggests that pretreatment examination of the serum MYO5A level could provide powerful evidence for prognosis assessment and individual therapeutic planning.

## Discussion

Laryngeal cancer is the 11th most common malignancy in the world.[51] Its treatment is becoming more effective due to developments in surgery and radiotherapy, but there has not been any significant improvement in the 5-year survival rate of patients with LSCC over the past 20 years.[7] Cervical nodal metastasis, especially occult metastasis, is generally responsible for poor outcomes.[52] Therefore, we were eager to identify an indicator of neck lymph node metastasis that could be used to assess the clinical prognosis of LSCC.

The suppressive functions of miR-145 are well documented in many solid malignancies,[11–28] but until now, its role in LSCC has not been determined. The functions of MYO5A in the development of cardiovascular system are well reported,[53] and several investigations have focused on

**Table 3** Evaluation of potential prognostic factors for LSCC

| Characteristic | Univariate analysis | | | Multivariate analysis | | |
|---|---|---|---|---|---|---|
| | HR | 95% CI | *P*-value | HR | 95% CI | *P*-value |
| Sex | 0.455 | 0.140–1.475 | 0.189 | – | – | – |
| Age | 0.770 | 0.411–1.442 | 0.414 | – | – | – |
| Primary location | 1.580 | 0.849–2.940 | 0.149 | – | – | – |
| Differentiation | **0.393** | **0.181–0.853** | **0.018** | 0.450 | 0.201–1.008 | 0.052 |
| T stage | **1.505** | **0.960–2.007** | **0.023** | **1.461** | **0.981–1.995** | **0.047** |
| Neck lymph node metastasis | **1.815** | **1.038–3.142** | **0.003** | **1.629** | **1.004–2.314** | **0.029** |
| MiR-145 level | **0.621** | **0.327–1.102** | **0.041** | 0.662 | 0.298–1.004 | 0.194 |
| Serum MYO5A level | **1.592** | **0.992–2.138** | **0.021** | **1.631** | **1.013–2.417** | **0.038** |
| Tissue MYO5A level | **1.941** | **0.879–3.244** | **0.148** | – | – | – |

**Note:** Statistically significant factors are shown in bold.
**Abbreviations:** LSCC, laryngeal squamous cell carcinoma; miR-145, microRNA-145.

the role of MYO5A in malignant melanoma.[41–44] Studies have also revealed that MYO5A is associated with metastasis.[45,46] Dynoodt et al found decreased MYO5A mRNA and protein in miR-145 overexpressing melanoma cells[48] but did not demonstrate a regulatory relationship between miR-145 and MYO5A. In addition, the functions and regulatory mechanisms of MYO5A in LSCC proliferation and neck lymph node metastasis are not well defined. In the present study, aberrant expression of miR-145 and MYO5A were observed in 132 LSCC tissues, with an inverse correlation between their levels. Moreover, the clinicopathological parameters of the 132 patients were extracted from inpatient records to explore the functions of miR-145 and MYO5A in human LSCC development. T stage, cell differentiation, and cervical metastatic state were recognized as factors affected by miR-145 expression. MYO5A expression was associated with the T stage and cervical metastatic state. This revealed the possibility that miR-145 suppresses the progression and metastasis of human LSCC by inhibiting MYO5A, and this was confirmed in vitro. We transfected Hep-2 cells with miR-145 mimic and MYO5A-specific siRNA. Hep-2 cells with miR-145 overexpression showed decreased MYO5A expression, proliferation, and invasion but increased apoptosis. Similar results were obser[illegible] Hep-2 cells with knockdown of MYO5A. Luciferase reporter assays demonstrated the regulatory relation[illegible]ip betw[illegible] miR-145 and MYO5A, indicating that mi[illegible]-145 s[illegible]ppress[illegible] the proliferation and invasion of He[illegible]2 cells [illegible]directly suppressing MYO5A expression. [illegible] our k[illegible]wledge, this is the first study that indicates th[illegible]iR-145 ca[illegible]uppress the development of human LSC[illegible] by ta[illegible]eting MYO5A.

In addition, we also d[illegible]covered that s[illegible]um MYO5A levels are a valuable predi[illegible]or of cer[illegible]ical nodal occult metastasis, and can be used to [illegible]sess [illegible]ognosis. Cervical nodal occult metastasis is i[illegible]isible [illegible] clinical [illegible]amination (eg, physical examinati[illegible]n or C[illegible] scan) [illegible]e surgery or radiotherapy. When [illegible]k lym[illegible]e metastasis occurs after treatment, the salvage su[illegible]y is always difficult and often has little success. It is therefore [illegible]ucial to find a clinically useful indicator to predict occult n[illegible]ck lymph node metastasis. Mendez et al reported the use of a 4-gene model (MYO5A, ring finger protein 145, F-box protein 32, and CTONG2002744) as a predictive indicator for cervical nodal metastasis.[47] These results provide the possibility of predicting cervical nodal occult metastasis, but the method has not been widely adapted in clinical practice. We detected serum MYO5A levels using ELISA, which is very common in clinical practice. In addition, we defined cervical nodal metastasis during follow-up for at least 3 years rather than simply during surgery, which highlighted the important predictive value of serum MYO5A levels. The AUC demonstrated the promise of this method for use in clinical practice. Serum MYO5A levels can be simply measured before surgery or radiotherapy, enabling the formation of suitable therapy plans for neck lymph node metastasis-negative patients.

Collectively, we demonstrated that miR-145 suppresses human LSCC progression and metastasis by inhibiting MYO5A. Serum MYO5A may be an effective predictor of neck lymph node metastasis and patient prognosis. H[illegible]wever, a trial with 132 samples is not large enough to c[illegible]nfirm the p[illegible]dictive ability of serum MYO5A levels. Further c[illegible]nical trials w[illegible] larger sample sizes will be required to [illegible]nfirm th[illegible] conclusi[illegible]n.

## Acknowledgment

This study w[illegible] suppo[illegible] by the [illegible]ational Natural Science Foundatio[illegible] China (No 8[illegible]64). This funding played an important role i[illegible] experimental conduction, data collection, and [illegible] analysis.

## Disclosure

The authors [illegible]port no conflicts of interest in this work.

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# Supplementary material

**Table S1** The clinical parameters of all the LSCC patients

| No | Gender | Age (years) | Primary location | Diagnosis | Cervical state | Differentiation | Surgical procedures |
|---|---|---|---|---|---|---|---|
| 1 | Male | 49 | Glottic | T2N0M0 | $N^-$ | High | Partial laryngectomy |
| 2 | Male | 68 | Supraglottic | T4N1M0 | $N^+$ | High | Total laryngectomy+bilateral neck dissections |
| 3 | Male | 71 | Glottic | T3N0M0 | $N^-$ | Moderate | Total laryngectomy |
| 4 | Male | 54 | Glottic | T2N0M0 | $N^-$ | High | Partial laryngectomy |
| 5 | Male | 59 | Supraglottic | T4N1M0 | $N^+$ | Moderate | Total laryngectomy+bilateral neck dissections |
| 6 | Male | 64 | Supraglottic | T3N0M0 | $N^-$ | High | Partial laryngectomy+unilateral neck dissections |
| 7 | Male | 73 | Supraglottic | T4N1M0 | $N^+$ | High | Total laryngecto[illegible]l neck dissections |
| 8 | Male | 71 | Glottic | T4N1M0 | $N^+$ | High | Total laryngec[illegible]my+bilatera[illegible]ck dissections |
| 9 | Female | 52 | Glottic | T3N0M0 | $N^-$ | Moderate | Total laryng[illegible]my |
| 10 | Male | 65 | Glottic | T3N0M0 | $N_0^+$ | High | Partial[illegible]y+bilateral[illegible]ck dissections |
| 11 | Male | 72 | Glottic | T4N1M0 | $N^+$ | Low | To[illegible]laryngectomy[illegible]ck dissections |
| 12 | Female | 75 | Glottic | T2N0M0 | $N^-$ | Low | [illegible]rtial lar[illegible]ctomy |
| 13 | Male | 63 | Glottic | T2N0M0 | $N^-$ | High | [illegible]ngectomy |
| 14 | Male | 61 | Glottic | T2N0M0 | $N^-$ | High | Parti[illegible]ryngect[illegible]y |
| 15 | Male | 67 | Glottic | T2N0M0 | $N_0^+$ | High | Total la[illegible]omy |
| 16 | Male | 65 | Glottic | T3N1M0 | $N^+$ | Moder[illegible] | Total laryngectomy+bilateral neck dissections |
| 17 | Male | 73 | Glottic | T2N0M0 | $N^-$ | High | [illegible]rtial laryngectomy |
| 18 | Female | 75 | Glottic | T2N0M0 | $N_0^+$ | [illegible]igh | Pa[illegible]al laryngectomy+bilateral neck dissections |
| 19 | Male | 48 | Glottic | T2N0M0 | $N_0^+$ | High | Partial laryngectomy+bilateral neck dissections |
| 20 | Male | 47 | Glottic | T3N0M0 | $N^-$ | High | Partial laryngectomy+bilateral neck dissections |
| 21 | Male | 63 | Glottic | T2N0M0 | $N^-$ | [illegible]igh | Partial laryngectomy |
| 22 | Male | 65 | Supraglottic | T3N1M0 | [illegible] | M[illegible] | Total laryngectomy+bilateral neck dissections |
| 23 | Male | 76 | Glottic | T3N0M0 | [illegible] | Moderate | Partial laryngectomy+unilateral neck dissections |
| 24 | Male | 54 | Supraglottic | T2N0M0 | N[illegible] | [illegible] | Partial laryngectomy |
| 25 | Male | 75 | Glottic | T2[illegible] | $N^-$ | High | Partial laryngectomy+bilateral neck dissections |
| 26 | Male | 51 | Glottic | [illegible]2N0M0 | $N^-$ | Moderate | Partial laryngectomy |
| 27 | Male | 62 | Supraglottic | T4N1M[illegible] | $N^+$ | High | Total laryngectomy+bilateral neck dissections |
| 28 | Male | 72 | Glottic | [illegible]0 | $N^-$ | High | Total laryngectomy+unilateral neck dissections |
| 29 | Male | 71 | Supra[illegible]ttic | T2[illegible]0 | $N_0^+$ | Moderate | Partial laryngectomy+bilateral neck dissections |
| 30 | Female | 47 | G[illegible]ttic | T2N1M[illegible] | $N_0^+$ | High | Partial laryngectomy+bilateral neck dissections |
| 31 | Male | 65 | Supraglotti[illegible] | T3N1M0 | $N_0^+$ | High | Partial laryngectomy+bilateral neck dissections |
| 32 | Male | 62 | Supraglottic | T3N1M0 | $N^+$ | High | Total laryngectomy+bilateral neck dissections |
| 33 | Male | 65 | Gl[illegible]ttic | T3N1M0 | $N^+$ | Low | Partial laryngectomy+bilateral neck dissections |
| 34 | Male | 5[illegible] | [illegible]lottic | T3N0M0 | $N^-$ | High | Total laryngectomy+unilateral neck dissections |
| 35 | Male | 58 | Glottic | T2N0M0 | $N^-$ | High | Total laryngectomy |
| 36 | Male | [illegible]9 | Supr[illegible]ottic | T3N1M0 | $N_0^+$ | Moderate | Partial laryngectomy+bilateral neck dissections |
| 37 | M[illegible] | [illegible] | [illegible]praglottic | T3N0M0 | $N_0^+$ | Moderate | Total laryngectomy+bilateral neck dissections |
| 38 | [illegible] | [illegible] | Glottic | T4N3M0 | $N^+$ | High | Total laryngectomy+bilateral neck dissections |
| 39 | Male | 77 | Glottic | T2N0M0 | $N^-$ | Moderate | Partial laryngectomy |
| 40 | Male | 59 | Glottic | T3N0M0 | $N_0^+$ | Moderate | Partial laryngectomy+unilateral neck dissections |
| 41 | Male | [illegible]0 | Glottic | T2N1M0 | $N^+$ | High | Partial laryngectomy+bilateral neck dissections |
| 42 | Male | 66 | Glottic | T2N0M0 | $N^-$ | Moderate | Partial laryngectomy |
| 43 | Male | 42 | Supraglottic | T3N0M0 | $N^-$ | High | Total laryngectomy+unilateral neck dissections |
| 44 | Male | 46 | Glottic | T3N0M0 | $N^-$ | Moderate | Total laryngectomy |
| 45 | Male | 46 | Supraglottic | T2N0M0 | $N^-$ | High | Partial laryngectomy+bilateral neck dissections |
| 46 | Male | 54 | Glottic | T2N0M0 | $N^-$ | High | Partial laryngectomy+unilateral neck dissections |
| 47 | Male | 76 | Supraglottic | T2N1M0 | $N_0^+$ | High | Partial laryngectomy+bilateral neck dissections |
| 48 | Male | 65 | Glottic | T2N0M0 | $N^-$ | High | Partial laryngectomy |
| 49 | Male | 48 | Supraglottic | T3N1M0 | $N^+$ | Low | Total laryngectomy+bilateral neck dissections |
| 50 | Female | 78 | Glottic | T3N1M0 | $N_0^+$ | High | Partial laryngectomy+bilateral neck dissections |

(*Continued*)

RETRACTED

**Table S1** (*Continued*)

| No | Gender | Age (years) | Primary location | Diagnosis | Cervical state | Differentiation | Surgical procedures |
|---|---|---|---|---|---|---|---|
| 51 | Female | 56 | Glottic | T3N0M0 | $N^-$ | High | Total laryngectomy |
| 52 | Male | 75 | Supraglottic | T3N0M0 | $N^-$ | Moderate | Partial laryngectomy+unilateral neck dissections |
| 53 | Male | 70 | Supraglottic | T2N1M0 | $N^+$ | Moderate | Partial laryngectomy+bilateral neck dissections |
| 54 | Male | 60 | Supraglottic | T3N0M0 | $N^-$ | High | Total laryngectomy+unilateral neck dissections |
| 55 | Male | 77 | Glottic | T3N0M0 | $N^-$ | Low | Total laryngectomy |
| 56 | Male | 80 | Supraglottic | T3N1M0 | $N_0^+$ | High | Total laryngectomy+bilateral neck dissections |
| 57 | Male | 74 | Glottic | T2N0M0 | $N^-$ | Low | Partial laryngectomy |
| 58 | Male | 66 | Supraglottic | T3N0M0 | $N^-$ | Moderate | Partial laryngectomy+unilateral neck dissections |
| 59 | Male | 74 | Glottic | T2N1M0 | $N_0^+$ | High | Partial laryngectomy+bilateral neck dissections |
| 60 | Male | 50 | Supraglottic | T3N1M0 | $N_0^+$ | Low | Total laryngectomy+bi[illegible] dissections |
| 61 | Male | 47 | Glottic | T3N0M0 | $N_0^+$ | High | Partial laryngectom[illegible]ilateral nec[illegible]issections |
| 62 | Male | 76 | Glottic | T3N0M0 | $N^-$ | High | Total laryngecto[illegible]nilateral neck[illegible]ssections |
| 63 | Male | 53 | Glottic | T4N1M0 | $N^+$ | Low | Total laryn[illegible]tomy+[illegible]teral neck [illegible]sections |
| 64 | Male | 46 | Supraglottic | T3N0M0 | $N^-$ | High | Partial l[illegible]ngectomy+uni[illegible]ral n[illegible]k dissections |
| 65 | Female | 45 | Glottic | T2N0M0 | $N^-$ | High | Parti[illegible]aryngect[illegible]y+bilater[illegible]eck dissections |
| 66 | Male | 72 | Glottic | T3N0M0 | $N^-$ | Moderate | T[illegible]ngec[illegible]omy+unila[illegible]ral neck dissections |
| 67 | Male | 49 | Glottic | T2N0M0 | $N^-$ | Low | Partial lar[illegible]ectomy |
| 68 | Male | 60 | Glottic | T3N0M0 | $N^-$ | High | Total laryngec[illegible]m[illegible]unilateral neck dissections |
| 69 | Male | 69 | Glottic | T2N1M0 | $N_0^+$ | Moderate | [illegible]tial laryngectomy+bilateral neck dissections |
| 70 | Male | 67 | Glottic | T4N2M0 | $N^+$ | High | Tota[illegible]ryngectomy+bilateral neck dissections |
| 71 | Female | 47 | Glottic | T2N0M0 | $N^-$ | Mo[illegible]ate | Partial l[illegible]ngectomy |
| 72 | Male | 62 | Glottic | T3N0M0 | $N^-$ | H[illegible] | Total laryngectomy+unilateral neck dissections |
| 73 | Male | 51 | Supraglottic | T4N1M0 | $N^+$ | H[illegible] | Total laryngectomy+bilateral neck dissections |
| 74 | Male | 63 | Glottic | T3N0M0 | $N^-$ | Hig[illegible] | Partial laryngectomy+unilateral neck dissections |
| 75 | Male | 68 | Supraglottic | T2N0M0 | $N^-$ | High | Partial laryngectomy |
| 76 | Female | 74 | Glottic | T4N1M0 | $N^+$ | [illegible] | Total laryngectomy+bilateral neck dissections |
| 77 | Male | 36 | Supraglottic | T2N0M0 | $N^-$ | [illegible]igh | Partial laryngectomy+bilateral neck dissections |
| 78 | Male | 62 | Glottic | T2N0M[illegible] | $N_0^+$ | High | Partial laryngectomy+bilateral neck dissections |
| 79 | Female | 56 | Supraglottic | T2N[illegible]0 | [illegible] | High | Partial laryngectomy+bilateral neck dissections |
| 80 | Male | 54 | Supraglottic | T[illegible]1M0 | [illegible] | Low | Total laryngectomy+bilateral neck dissections |
| 81 | Male | 62 | Supraglottic | T3N[illegible] | $N^-$ | High | Total laryngectomy+unilateral neck dissections |
| 82 | Male | 80 | Supraglotti[illegible] | T2N0M[illegible] | $N^-$ | High | Partial laryngectomy+bilateral neck dissections |
| 83 | Male | 63 | Supra[illegible]tic | T4N2M0 | $N^+$ | High | Total laryngectomy+bilateral neck dissections |
| 84 | Female | 70 | Glottic | [illegible]N0M0 | $N^-$ | Moderate | Partial laryngectomy |
| 85 | Male | 69 | [illegible]praglottic | T4[illegible]M0 | $N^+$ | High | Total laryngectomy+bilateral neck dissections |
| 86 | Male | 77 | Glottic | T4N2M0 | $N^+$ | Low | Total laryngectomy+bilateral neck dissections |
| 87 | Male | 80 | Glo[illegible] | T4N1M0 | $N^+$ | Moderate | Total laryngectomy+bilateral neck dissections |
| 88 | Male | 76 | [illegible]ttic | T3N0M0 | $N_0^+$ | High | Partial laryngectomy+bilateral neck dissections |
| 89 | Male | 79 | S[illegible]praglot[illegible] | T4N1M0 | $N^+$ | Moderate | Total laryngectomy+bilateral neck dissections |
| 90 | Female | 66 | Glot[illegible] | T3N1M0 | $N_0^+$ | High | Total laryngectomy+bilateral neck dissections |
| 91 | Female | 61 | [illegible]ttic | T3N0M0 | $N^-$ | Moderate | Partial laryngectomy+unilateral neck dissections |
| 92 | Male | [illegible] | Supraglottic | T2N1M0 | $N_0^+$ | High | Partial laryngectomy+bilateral neck dissections |
| 93 | Female | [illegible] | Supraglottic | T3N0M0 | $N_0^+$ | High | Total laryngectomy+bilateral neck dissections |
| 94 | Male | 74 | Glottic | T3N0M0 | $N^-$ | High | Partial laryngectomy+unilateral neck dissections |
| 95 | Male | 46 | Supraglottic | T4N2M0 | $N^+$ | Low | Total laryngectomy+bilateral neck dissections |
| 96 | Male | 57 | Glottic | T3N0M0 | $N^-$ | High | Total laryngectomy |
| 97 | Male | 66 | Glottic | T2N1M0 | $N_0^+$ | High | Partial laryngectomy+bilateral neck dissections |
| 98 | Male | 63 | Glottic | T3N0M0 | $N^-$ | Moderate | Partial laryngectomy+unilateral neck dissections |
| 99 | Female | 61 | Supraglottic | T3N0M0 | $N^-$ | High | Total laryngectomy+unilateral neck dissections |
| 100 | Male | 67 | Glottic | T3N0M0 | $N^-$ | High | Partial laryngectomy+unilateral neck dissections |
| 101 | Female | 70 | Supraglottic | T2N1M0 | $N^+$ | Low | Partial laryngectomy+bilateral neck dissections |
| 102 | Male | 50 | Glottic | T3N0M0 | $N^-$ | Low | Total laryngectomy |
| 103 | Male | 57 | Supraglottic | T3N0M0 | $N^-$ | Moderate | Partial laryngectomy+unilateral neck dissections |

(*Continued*)

RETRACTED

**Table S1** (*Continued*)

| No | Gender | Age (years) | Primary location | Diagnosis | Cervical state | Differentiation | Surgical procedures |
|---|---|---|---|---|---|---|---|
| 104 | Male | 47 | Supraglottic | T3N0M0 | $N^-$ | High | Total laryngectomy+unilateral neck dissections |
| 105 | Male | 64 | Supraglottic | T3N1M0 | $N_0^+$ | Low | Partial laryngectomy+bilateral neck dissections |
| 106 | Male | 71 | Supraglottic | T2N0M0 | $N^-$ | High | Partial laryngectomy |
| 107 | Male | 51 | Supraglottic | T2N0M0 | $N^-$ | High | Partial laryngectomy+bilateral neck dissections |
| 108 | Male | 70 | Supraglottic | T4N1M0 | $N^+$ | Low | Total laryngectomy+bilateral neck dissections |
| 109 | Female | 48 | Supraglottic | T3N1M0 | $N_0^+$ | Low | Total laryngectomy+unilateral neck dissections |
| 110 | Male | 67 | Glottic | T2N0M0 | $N^-$ | High | Partial laryngectomy+bilateral neck dissections |
| 111 | Male | 80 | Glottic | T3N0M0 | $N_0^+$ | Low | Partial laryngectomy+bilateral neck dissections |
| 112 | Female | 77 | Glottic | T3N0M0 | $N_0^+$ | High | Total laryngectomy |
| 113 | Male | 35 | Glottic | T2N0M0 | $N^-$ | High | Partial laryngecto |
| 114 | Male | 58 | Glottic | T3N1M0 | $N^+$ | High | Total laryngec my+bilatera eck dissections |
| 115 | Male | 45 | Supraglottic | T3N2M0 | $N^+$ | High | Total laryng my+bilateral n k dissections |
| 116 | Male | 76 | Glottic | T3N1M0 | $N_0^+$ | High | Partial ryngect +bilateral ck dissections |
| 117 | Male | 72 | Supraglottic | T3N1M0 | $N_0^+$ | High | To laryngectomy ater eck dissections |
| 118 | Male | 79 | Glottic | T3N0M0 | $N^-$ | High | rtial lary ectomy+u teral neck dissections |
| 119 | Male | 80 | Supraglottic | T3N0M0 | $N^-$ | High | gectomy nilateral neck dissections |
| 120 | Male | 57 | Glottic | T2N0M0 | $N^-$ | High | Parti ryngect y |
| 121 | Male | 64 | Supraglottic | T2N0M0 | $N^-$ | High | Partial la omy+bilateral neck dissections |
| 122 | Male | 52 | Glottic | T2N0M0 | $N^-$ | Low | Partial laryngectomy |
| 123 | Male | 56 | Supraglottic | T3N0M0 | $N^-$ | High | rtial laryngectomy+unilateral neck dissections |
| 124 | Male | 77 | Glottic | T2N0M0 | $N^-$ | igh | Pa al laryngectomy |
| 125 | Male | 50 | Supraglottic | T3N0M0 | $N^-$ | High | Total laryngectomy+unilateral neck dissections |
| 126 | Male | 52 | Supraglottic | T2N0M0 | $N^-$ | High | Partial laryngectomy+unilateral neck dissections |
| 127 | Male | 65 | Supraglottic | T4N1M0 | $N^+$ | ow | Total laryngectomy+bilateral neck dissections |
| 128 | Male | 58 | Supraglottic | T3N1M0 | | Lo | Total laryngectomy+unilateral neck dissections |
| 129 | Male | 76 | Glottic | T3N0M0 | | High | Partial laryngectomy+unilateral neck dissections |
| 130 | Male | 69 | Supraglottic | T2N0M0 | N | High | Partial laryngectomy+unilateral neck dissections |
| 131 | Male | 47 | Supraglottic | T2 | $N^-$ | High | Partial laryngectomy+bilateral neck dissections |
| 132 | Male | 77 | Glottic | 2N0M0 | $N^-$ | High | Partial laryngectomy |

**Abbreviation:** LSCC, laryngeal squamous cell carcino

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