Reviewers' comments:

Reviewer #1 (Remarks to the Author):

Using summary statistics from GWAS, the study quantified the genetic correlations among cancers, their subtypes, as well as with other non-cancer traits. They also assessed the proportion of cancer heritability attributable to specific functional categories to identify functional elements that are enriched for SNP-heritability. Overall the study is well conducted. I have a few comments for the authors to consider.

1. The study can be viewed as a cross-sectional study on the genetic levels and has limited ability for inferring causality (ie, the shared roots of genetic causes). Thus, it is unclear what information the study adds to what we have already known about the shared risk factors among many cancers (eg, smoking for lung and head and neck cancer) and the causal relationship b/t certain traits and cancer (eg, obesity and colorectal cancer). What is even more concerning is that some of the wellknown relationships is not supported by the current study (eg, reproductive factors and breast cancer), raising questions about the study methodology (eg, reliance on the GWAS findings and lack of consideration of rare loci). Also, as acknowledged by the authors, even the observed genetic correlations between traits are subject to confounding by other common risk factors. 2. The first part of the results on heritability estimates is very interesting. It is surprising to see that common GWAS loci can almost entirely explain the classical heritability of head/neck cancer and explain 30-40% of heritability for other cancers. This does not seem to be consistent with the literature about the limited heritability that GWAS loci explains for most cancers, and deserves some mention in the abstract and detailed discussion. If the current study finding is correct, however, we would not expect much contradiction with the Mendelian randomization studies about the relationship b/t risk factors and common cancers since the MR studies are completely based on the identified GWAS loci.

3. The selection criteria for non-cancer traits are unclear. While most of the traits can be considered as cancer risk factors, others are more symptoms-related (eg, lung function for lung cancer, psychiatric factors). On the other hand, other well-established cancer risk factors are not considered, such as infection. A more structured, hypothesis-driven selection process may be considered to clarify the aims of the investigation and facilitate downstream inference.

Reviewer #2 (Remarks to the Author):

This study presents the largest analysis of genetic correlations among different solid cancers. While this type of study is not novel, the very large increase in sample size has enabled detection of a large number of shared genetic effects that will potentially lead to important advances in this field. The study relies primarily on LD score regression that has some advantages over other approaches to examine GWAS signal correlations. In addition, interesting local genetic correlations as well as analyses of enrichment of cancer heritability due to epigenetic and other putative functional elements are valuable additions. Overall, the study the presentation is balanced and well written.

Some suggestive clarifications.

1. Methods – Some additional details concerning QA should be included within the methods and not simply referenced. These include indicating briefly the computational algorithm for imputing, quality of imputed SNPs (r2 or other criteria), and any other data cleaning (HW exclusion etc.). Also, it unclear whether these studies used a final common SNP set (number of SNPs should be indicated) among the solid cancers and between these cancers and other non-cancer traits. If not, the final SNP number should be included for each component. If a common set of SNPs was not used some discussion about how this would affect the analyses should be considered. a. It is not clear to me whether the LDSR can distinguish between opposite effects (protective vs. risk) when comparing phenotypes. This might be worth a comment.

2. It would be useful to provide in a supplemental Table the number of regions (+/- 500 kb) for each cancer that reach the 5x10-8 threshold (p values) and some measure of effect size. This would be of value in providing additional context for the contribution of known loci to the h2g calculations (e.g. differences between head and neck vs. lung cancer).

3. It would be interesting to see whether combinations of identified GWAS loci/regions (5x10-8 +/- 500 kb) in different solid cancers could explain a higher proportion of the GWAS calculated h2g. For example, can the lung cancer 5x10-8 GWAS loci explain a proportion of the head and neck GWAS calculated h2. Perhaps excluding these regions would be more informative in assessing whether how much of the overlap is due mostly to large numbers of unidentified GWAS loci (i.e. how is the genetic sharing affected if the 5x10-8 regions are excluded?).

4. Some comment concerning whether population structure differences between studies of different European populations (i.e. potential for differences in population groups between different cancers) and how this could affect LDSC.

5. Some empiric assessment of the sensitivity of the LD regression analysis to sample size or more importantly, study origin, affect the analyses. For example, do smaller sets of squamous lung cancer derived from different studies show approach sharing of 1.0. Do these smaller squamous lung cancer sets show similar rg with adenocarcinoma.

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1. The study can be viewed as a cross-sectional study on the genetic levels and has limited ability for inferring causality (eg, the shared roots of genetic causes). Thus, it is unclear what information the study adds to what we have already known about the shared risk factors among many cancers (eg, smoking for lung and head and neck cancer) and the causal relationship b/t certain traits and cancer (eg, obesity and colorectal cancer). What is even more concerning is that some of the well-known relationships is not supported by the current study (eg, reproductive factors and breast cancer), raising questions about the study methodology (eg, reliance on the GWAS findings and lack of consideration of rare loci). Also, as acknowledged by the authors, even the observed genetic correlations between traits are subject to confounding by other common risk factors.

Response: We thank the reviewer for raising these potential concerns. The main purpose of our manuscript is to understand the magnitude of genetic correlation among cancers, which may have important implications for the biology and future study design (e.g., would a pan-cancer GWAS make sense?). We note that comprehensive Mendelian randomization analyses between non-cancer traits and the included cancers are beyond the scope of our current study, and are topics of ongoing research projects of other groups within the same network.

In this study, we explored the relationship between potential risk factors and cancer using two different approaches. We first conducted genome-wide genetic correlation analyses which take all common SNPs in the genome into account, regardless of their statistical significance. In addition, we assessed the directional genetic correlations between potential risk factors and cancers, which could also provide causal interpretations (see Figure 4 in the original manuscript). Such analyses are based on genome-wide significant loci only and are unfortunately not feasible for traits with limited number of GWAS-identified SNPs such as smoking (only two loci have been identified).

In our directional genetic correlation analysis, we *did* find that SNPs associated with age at natural menopause showed correlated effect estimates with breast cancer but the reverse was not true; previous Mendelian randomization analyses have also identified a causal link between reproductive factors (e.g., age at menarche) and breast cancer, whereas we did not observe a significant genetic correlation using SNPs all over the genome. The lack of genome-wide correlation could be due to the sparse nature of the correlation, and the sample size.

We thus argued in our discussion that "…… *It is possible that a relatively small overlap in strongly associated SNPs can result in significant MR results despite low evidence of an overall genetic correlation.* ……"

2. The first part of the results on heritability estimates is very interesting. It is surprising to see that common GWAS loci can almost entirely explain the classical heritability of head/neck cancer and explain 30-40% of heritability for other cancers. This does not seem to be consistent with the literature about the limited heritability that GWAS loci explains for most cancers, and deserves some mention in the abstract and detailed discussion. If the current study finding is correct, however, we would not expect much contradiction with the Mendelian randomization studies about the relationship b/t risk factors and common cancers since the MR studies are completely based on the identified GWAS loci.

Response: We thank the reviewer for this opportunity to further clarify our results. If we define the classical twin studies or familial studies narrow sense heritability as h^2 , heritability explained by common SNPs (SNPs across the whole genome) or SNP-heritability as h_g^2 , and heritability explained by known GWAS loci (significant GWAS SNPs) as h_{GWAS}^2 , indeed, the classical heritability can be explained almost entirely (head/neck cancer) or 30-40% (other cancers) by using all SNPs across the genome (h_g^2) , but not the GWAS-identified significant loci (h_{GWAS}^2) .

These numbers are consistent across multiple common traits. For example, the classical heritability (h^2) of rheumatoid arthritis is ~0.5 and genome-wide SNPs can explain almost half of this heritability (h_g^2 , 0.2 out of 0.5, 40%), whereas genome-wide significant SNPs could only explain 12% (h_{GWAS}^2 , 0.06 out of 0.5). Table 1 below was cited from Visscher *et al.* (PMID 22243964), where for most of the traits, all GWAS SNPs explain a majority (30-60%) of the classical heritability.

We note that head /neck cancer is a special case because of estimate variability. In our current study, the sample size of head/neck is the smallest among all cancers (N=5,452 cases and 5,984 controls), and its SNPheritability on the liability scale varies between 5-14% (point estimate 9%). Similarly, the largest available twin study of head/neck cancer, to which we compared our SNP-heritability, is based on only 196 monozygotic and 367 dizygotic twins, and the heritability varies between 0-60% (point estimate 9%). Comparing the point estimates, it seems that the classical heritability can be explained almost entirely for head/neck cancer, which may be influenced by limited sample size and power. We have explicitly mentioned the uncertainty of point estimates as a limitation in our discussion.

We note that Mendelian randomization analysis to explore if risk factor A is associated with cancer B will be based on the SNPs found to be genome-wide significantly associated with risk factor A and not with cancer B. Thus, the SNPs that are genome-wide significantly associated with cancer B are not considered in Mendelian randomization (unless they have shown genome-wide significance for both risk factor A and cancer B). Therefore, it is possible that even though common SNPs can explain a high proportion of the heritability of cancer, the individual GWAS SNPs for risk factor A, may only explain a very small part of the observed SNPheritability for cancer.

Trait or Disease	h ² Pedigree Studies	$h2$ GWAS Hits ^a	h^2 All GWAS SNPs b
Type 1 diabetes	0.9^{98}	0.6^{99} \approx	0.3^{12}
Type 2 diabetes	$0.3 - 0.6^{100}$	$0.05 - 0.10^{34}$	
Obesity (BMI)	$0.4 - 0.6^{101,102}$	$0.01 - 0.02^{36}$	0.2^{14}
Crohn's disease	$0.6 - 0.8^{103}$	0.1^{11}	0.4^{12}
Ulcerative colitis	0.5^{103}	0.05^{12}	
Multiple sclerosis	$0.3 - 0.8^{104}$	0.1^{45}	
Ankylosing spondylitis	$>0.90^{105}$	0.2^{106}	
Rheumatoid arthritis	0.6^{107}		
Schizophrenia	$0.7 - 0.8^{108}$	0.01^{79}	0.3^{109}
Bipolar disorder	$0.6 - 0.7^{108}$	0.02^{79}	0.4^{12}
Breast cancer	0.3^{110}	0.08^{111}	
Von Willebrand factor	$0.66 - 0.75$ ^{112,113}	0.13^{114}	0.25^{14}
Height	$0.8^{115,116}$	0.1^{13}	$0.5^{13,14}$
Bone mineral density	$0.6 - 0.8$ ¹¹⁷	0.05^{118}	
QT interval	$0.37 - 0.60$ ^{119,120}	0.07^{121}	0.2^{14}
HDL cholesterol	0.5^{122}	0.1^{57}	
Platelet count	0.8^{123}	$0.05 - 0.1$ ⁵⁸	

Table 1. Population Variation Explained by GWAS for a Selected

3. The selection criteria for non-cancer traits are unclear. While most of the traits can be considered as cancer risk factors, others are more symptoms-related (eg, lung function for lung cancer, psychiatric factors). On the other hand, other well-established cancer risk factors are not considered, such as infection. A more structured, hypothesis-driven selection process may be considered to clarify the aims of the investigation and facilitate downstream inference.

Response: We thank the reviewer for raising this point. The purpose of the genetic correlation analyses between non-cancer traits and cancer was two-fold. First, we wanted to quantify the genetic correlation between established risk factors (such as smoking, obesity), but we also wanted to conduct exploratory analyses to discover novel relationships. Our non-cancer traits were selected based on data availability and is mostly hypothesis free. We collected GWAS summary statistics from UK Biobank as well as other publically available GWAS summary results. Among those traits, we calculated trait-specific SNP-heritability and restricted our analysis only to traits with a heritable component (z-score > 7). This quality control procedure may preclude some of the traits (e.g., with a small sample size, or no signs of heritability) from being included in our study.

We have explicitly mentioned this as a limitation in our discussion, it reads, "…… *We were not able to consider all cancer risk factors when selecting non-cancer traits, since some of the well-established risk factors such as infection were either not available, showed no evidence of heritability or were not based on adequate sample sizes for robust analyses. ……"*

Reviewer #2:

This study presents the largest analysis of genetic correlations among different solid cancers. While this type of study is not novel, the very large increase in sample size has enabled detection of a large number of shared genetic effects that will potentially lead to important advances in this field. The study relies primarily on LD score regression that has some advantages over other approaches to examine GWAS signal correlations. In addition, interesting local genetic correlations as well as analyses of enrichment of cancer heritability due to epigenetic and other putative functional elements are valuable additions. Overall, the study the presentation is balanced and well written.

Thank you.

Some suggestive clarifications.

1. Methods – Some additional details concerning QA should be included within the methods and not simply referenced. These include indicating briefly the computational algorithm for imputing, quality of imputed SNPs $(r^2$ or other criteria), and any other data cleaning (HW exclusion etc.). Also, it unclear whether these studies used a final common SNP set (number of SNPs should be indicated) among the solid cancers and between these cancers and other non-cancer traits. If not, the final SNP number should be included for each component. If a common set of SNPs was not used some discussion about how this would affect the analyses should be considered.

a. It is not clear to me whether the LDSR can distinguish between opposite effects (protective vs. risk) when comparing phenotypes. This might be worth a comment.

Response: Following the reviewer's suggestion, we have summarized the additional details of quality control in Supplement 1, including the computational algorithm for imputation, the reference panel, quality of imputed SNPs, and data cleaning strategy. This table has also been included in our manuscript. For more details, we encourage the reader to look into the original GWAS paper of each cancer (Michailidou *et al.*, PMID 29059683; McKay *et al.*, PMID 28604730; Lesseur *et al.*, PMID 27749845; Schmit *et al.*, PMID 29917119; Phelan *et al.*, PMID 28346442; Schumacher *et al.*, PMID 29892016).

For all our SNP-heritability and genetic correlation analysis, we used a final common SNP set. We have further clarified this in our Methods, "…… *We included autosomal SNPs with a minor allele frequency (MAF) larger than 1% and present in HapMap3 because those SNPs are usually well imputed in most studies (N_{SNPs} =* \sim *1) million).* ……".

LDSC can distinguish between concordant effects—where the same allele is associated with an increase in both traits being compared—and opposite effects—where the same allele is associated with an increase in one trait but a decrease in the other. LDSC calculates the correlation in regression coefficients for the two traits across all SNPs. This genetic correlation ranges between −1 to 1, so LDSC can distinguish opposite effects (positive or negative genetic correlation).

In a previous paper published by Bulik-Sullivan *et al.* (PMID 26414676), several negative genetic correlations have been observed between traits such as anorexia nervosa and obesity, height and coronary artery disease, college attendance and Alzheimer's disease, smoking and college attendance, and are consistent with epidemiological reports. We have also identified, in our current manuscript, negative genetic correlations of educational attainment with multiple cancers.

This is also one of the reasons why it's possible to observe multiple regions that show local genetic correlation between two traits even though the overall genome-wide genetic correlation is minimal (e.g., lung and prostate cancer, see Figure 2 in the original manuscript). Because negative and positive significant local genetic correlations between two traits will cancel out in the overall genetic correlation and LDSC is sensitive to this.

Supplement1. Quality control and imputation procedures of each cancer.

2. It would be useful to provide in a supplemental Table the number of regions (+/- 500 kb) for each cancer that reach the 5×10⁻⁸ threshold (p-values) and some measure of effect size. This would be of value in providing

additional context for the contribution of known loci to the h^{2}_{g} calculations (e.g. differences between head and neck vs. lung cancer).

Response: We agree with the reviewer, and have listed the specific regions for each cancer that reached the 5×10⁻⁸ threshold (p-values), its chromosome, start and end positions (+/− 500 kb), and the most significant SNP (referred to as the "best SNP") of that region in the Supplement 2 below. This table has also been included in our manuscript.

Supplement2. The number of regions (+/- 500 kb) for each cancer that reach the $5x10^{-8}$ threshold (p-values) in each cancer and the best SNP in the region.

3. It would be interesting to see whether combinations of identified GWAS loci/regions (5×10⁻⁸ +/− 500 kb) in different solid cancers could explain a higher proportion of the GWAS calculated h²_g. For example, can the lung cancer 5 \times 10⁻⁸ GWAS loci explain a proportion of the head and neck GWAS calculated h²? Perhaps excluding these regions would be more informative in assessing whether how much of the overlap is due mostly to large numbers of unidentified GWAS loci (i.e. how is the genetic sharing affected if the 5×10^{-8} regions are excluded?).

Response: We thank the reviewer for raising this interesting point. We have performed two additional analyses to address this question. In results shown in Supplement 3, we present the heritability of each cancer using 1) all SNPs, 2) SNPs after removing identified GWAS loci from the cancer under study (results also shown in the original Supplementary Table 1), and 3) SNPs after removing identified GWAS loci for each of the other 5 cancers.

For most of the cancers, the GWAS significant loci for that particular cancer explain the most of its heritability. For some cancers, however, significant GWAS loci of other cancers also explain a non-trivial part of its heritability. For example, the significant breast cancer GWAS loci explained 10%, 15% and 22% heritability of colorectal, ovarian and prostate cancer, respectively; the significant colorectal cancer GWAS loci explained 11% heritability of prostate cancer; the significant lung cancer GWAS loci explained 10% heritability of head/neck cancer; and the significant prostate cancer GWAS loci explained 11% and 15% heritability of breast and ovarian cancer, respectively. These findings are consistent with the main genetic correlation results and reflect the shared genetic basis between cancers. We have described these results explicitly in the manuscript as well as added a supplementary table.

Supplement3. Estimates of SNP-heritability on the liability scale based on HapMap3 SNPs using LD score regression for each cancer, remove GWAS significant hits.

In Supplement 4, we calculated the cross-cancer genetic correlation based on data after excluding the GWAS significant regions of each cancer. The estimates were mostly consistent with the results calculated based on all SNPs. We compared the two sets of genetic correlations in a scatter plot (before *vs.* after removing GWAS significant regions), and got a Spearman's correlation coefficient of 0.97, which may indicate that the genetic sharing could be affected to some small extent if the 5×10^{-8} regions are excluded. We have added a sentence to the manuscript describing these results.

Supplement4. Estimates of cross-cancer genetic correlation based on HapMap3 SNPs using LD score regression for each cancer and its subsets, top hits with p-values < $5x10^{-8}$ +/- 500kb region were excluded.

The genetic correlations among cancer pairs, in the brackets were standard errors, followed by p-values. Bold red font: results withstood multiple corrections (Bonferroni correction, $P < 0.05/78 = 0.00064$); black bold font: results with nominal significance ($P < 0.05$).

Genetic correlation after removing regions with significant GWAS hits

4. Some comment concerning whether population structure differences between studies of different European populations (i.e. potential for differences in population groups between different cancers) and how this could affect LDSC.

Response: Intra-European differences as a source of bias in LDSC has been examined by a previous work of Bulik-Sullivan *et al.* (PMID 25642630). To explore the stability of LD Score across European-ancestry populations, the authors estimated LD Scores using each of the 1000 Genomes Project EUR subpopulations separately (Utah residents with Northern and Western European ancestry (CEU), British in England and Scotland (GBR), Toscani in Italia (TSI) and Finnish in Finland (FIN)). The LD Scores from all four subpopulations were highly correlated, but mean LD Score increased with latitude, consistent with the observation that southern European populations have gone through less severe bottlenecks than northern European populations.

The authors evaluated the impact of these differences on the behavior of the LD Score regression analysis and found that the EUR reference panel was adequate for studies in outbred populations of predominantly northern European ancestry, such as European-American or UK populations. Therefore, 1000 Genomes Project European ancestry reference panel LD Scores are a good approximation to in-sample LD Scores. For genetic correlation analyses, the LD score in the estimating equation is the cross product of the linkage disequilibrium correlations from the two GWAS samples (this reduces to the sum of squared correlations when both GWAS are identical, i.e. when calculating heritability for a single trait). Again, considering that our studies are predominantly of European-ancestry subjects (our data were based on GWAS meta-analysis from multiple individual GWAS across European ancestry populations from Europe, Australia and the US), the 1KGP reference LD scores should suffice. We believe that any population structure across cancers will have minimal effect on our results. We have added a paragraph to the discussion about this.

5. Some empiric assessment of the sensitivity of the LD regression analysis to sample size or more importantly, study origin, affect the analyses. For example, do smaller sets of squamous lung cancer derived from different studies show approach sharing of 1.0. Do these smaller squamous lung cancer sets show similar r_g with adenocarcinoma.

Response: We thank the reviewer for raising this interesting point; however, it is beyond the scope of our current analysis as we don't have access to the individual-level data. Based on our response to the previous question, we don't think the study origin would affect the genetic correlation estimates.

Due to logistical issues, we could only get a smaller set of ER-negative breast cancer derived from different studies. As shown in the table below, we extracted a smaller set (BCAC) from the overall study (BCAC+CIMBA). The genetic correlation between BCAC+CIMBA (N=133295) vs. BCAC (N=122032) ER-negative breast cancer is 1.00 (0.007). These two sets of data presented very similar genetic correlation with other cancers and subtypes.

Supplement5. The genetic correlation between ER-negative breast cancer and other cancers, overall data vs. a subset of data.

6. Last sentence in abstract is a bit strong – would suggest "…… suggests that solid tumors arising across tissues in part share a common germline genetic basis."

Response: We thank the reviewer for this edit. We have now modified the last sentence as the reviewer suggested, it reads, "Our comprehensive analysis of cross-cancer heritability suggests that solid tumors arising across tissues *in part* share a common germline genetic basis."

REVIEWERS' COMMENTS:

Reviewer #1 (Remarks to the Author):

The authors have addressed my comments. I do not have any further comments.

Reviewer #2 (Remarks to the Author):

The authors have addressed the concerns and suggestions provided in the initial review and the manuscript is substantially enhanced.

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