## **Table of contents**





**Supplementary Figure 1. Per subtype performance on RCC subtyping.** For different training set sizes, all 10 CLAM models trained on the public TCGA kidney dataset are evaluated. By considering the probability predictions and ground truth labels for the 3-class classification problem as one-vs-rest (OVR), the averaged ROC curve of 10 models (confidence band shows ±1 std) is drawn for each of the three classes (**left:** chromophobe, **middle:** clear cell and **right:**  papillary) on each RCC subtyping dataset: **a)** public TCGA kidney test set (n = 86), **b)** BWH independent test set (n = 135), **c)** BWH biopsy dataset (n = 92), and **d**) BWH cellphone dataset (n  $=$  135). Area under the curve (AUC) values are shown in figure legends ( $\pm$  std).



**Supplementary Figure 2. Model performance on in-house NSCLC resection WSIs for different scanner hardware.** Different scanner hardware produces different micron per pixel (mpp) resolution even at the same magnification. We evaluated the models trained on the public TCGA + CPTAC lung dataset (Aperio scans with an average 20x equivalent mpp of 0.50) on both WSIs (n = 131) digitized with an in-house Hamamatsu scanner (20x mpp: 0.44) and in-house 3DHistech scanner (20x mpp: 0.33). The 3DHistech scans were drastically different in terms of mpp from the training data and resulted in an average decrease of 6.5% in test AUC to 0.910  $\pm$ 0.022 from 0.975 ± 0.007. Notably, the drop in AUC performance is much larger for MIL and SL when evaluated on the 3DHistech scans, at 16.6% and 31.6% respectively. Additionally, we adjusted the mpp of our in-house scans to 0.5 by downscaling the image patches before they are embedded by the CNN feature encoder. When this simple technique is applied, the average test AUC of CLAM on the 3DHistech scans improved to 0.965 ± 0.006. These results demonstrate that CLAM is reasonably robust to technical variability introduced by different scanner hardware. The test AUC performance of all 10 trained models for each algorithm is shown for each configuration using box plot. Boxes indicate quartile values  $(1<sup>st</sup>, median, and 3<sup>rd</sup>)$  and whiskers extend to data points within 1.5x the interquartile range.



**Supplementary Figure 3. Performance of CLAM ensemble system on independent test sets.**  For each task, we took the 10 models trained on the public datasets using 10-fold monte-carlo cross-validation (recall 80% of cases in each dataset were used to train each model) and computed their ensemble predictions by averaging the normalized probability scores over all 10 readers for each slide in the independent test set. For BWH NSCLC subtyping and axillary lymph node metastasis detection, the test AUC of the ROC curve corresponding the ensemble predictions is computed along with its 95% confidence interval (CI). For BWH RCC subtyping, the one-vs-rest AUC and its 95% CI for each subtype is computed in addition to the macro-averaged AUC. See **Supplementary Table 12 – 14** for more details.



**Supplementary Figure 4. Attention heatmap visualization using varying degrees of overlap.**  In our study, CLAM uses  $256 \times 256$  patches to make predictions. By default, patches cover the entire extent of the tissue regions in each slide with a step size of 256 (no overlap) for fast training and inference. The resulting attention heatmap appears blocky as there can be large transitions in the attention scores assigned to neighboring patches. Instead of using interpolation techniques to estimate the attention scores for overlapped locations that are not sampled during patching, we increased the overlap between patches (up to 95% overlap) for fine-grained heatmap visualization. Attentions scores are first normalized to percentile scores by referring to the raw scores computed for all non-overlapped patch locations (this ensures that the same locations from the overlapped and non-overlapped heatmaps always have roughly the same normalized scores). Normalized attention scores are mapped to their corresponding spatial locations in the WSI and visualized (scores for overlapped regions are accumulated and averaged). As demonstrated in both the whole slide image (WSI) and cellphone image (CPI) example, using an overlap above 50% significantly reduces the blockiness of the resulting heatmap and using a 95% overlap renders the heatmap nearly completely smooth to a human observer.



**Supplementary Figure 5. Validation of attention heatmap for axillary lymph node metastasis using cytokeratin (AE1/AE3) immunohistochemical staining.** Subsequent slices of paraffinembedded tissue of several positive cases of axillary lymph node metastasis are collected, cut and stained with H&E and AE1/AE3 IHC, and digitized at BWH. In the representative example, a CLAM model trained on our public lymph node metastasis training set is tested on the entire tissue region (excluding fat) of the H&E WSI using overlapping patches and a fine-grained attention heatmap corresponding to the model's prediction is created. We find that in addition to correctly detecting metastasis at the slide-level, CLAM accurately attends to metastatic regions (red in attention heatmap, gold in corresponding IHC) and often even individual tumor cells in the side-byside comparison of the fine-grained attention heatmap and IHC-stained WSI. This promising finding suggests that while further validation is needed, in some circumstances, it might be possible to apply CLAM (which requires no pixel-level or ROI-level annotation and no special stains for training) to whole-slide-level segmentation tasks (including but not limited to predicting the corresponding IHC) that would otherwise incur either costly labor and human expertise or expensive reagents and core facilities.



**Supplementary Figure 6. Analysis of misclassified cases in the independent test sets.** The attention heatmaps and high attention patches can be utilized to analyze failure cases of the CLAM model. **a)** Example of squamous cell NSCLC misclassified as adenocarcinoma. Tumor regions were identified by the model and represented large, pleomorphic, poorly differentiated cells that lacked definite morphologic features or architecture of either adenocarcinoma (glandular formation, intracellular mucin, *etc.*) or squamous cell carcinoma (keratin formation, intracellular bridges, *etc.*). **b)** Example of papillary RCC misclassified as chromophobe. The model identified large, atypical, polygonal cells with either a clear or granular, eosinophilic cytoplasm in regions that did not have definitive fibrovascular cores, likely as a result of sectioning. **c)** Example of false positive misclassification in lymph node metastasis detection. The model identified larger cells with irregular nuclear contours and foamy cytoplasm, likely representing histiocytes that are commonly found within lymph nodes.





**Supplementary Figure 7. Quantitative assessment of attention heatmaps using pathologist annotations.** While attention heatmaps of CLAM models trained with only WSI-level labels were not intended for detailed annotation at the pixel-level, we attempted to quantitatively correlate the attention heatmaps of CLAM with tumor regions in WSIs. Two anatomic pathologists (AP) independently annotated all resection slides in our in-house RCC, NSCLC and Lymph node met. datasets. Attention heatmaps were first created by using the best performing CLAM model in terms of test AUC for each task with patches tiled at a 75% overlap and then thresholded to produce binary masks. Simple post processing techniques such as morphological closing followed by opening were used to reduce the fragmentation in the initial masks, close small holes and suppress small artifacts. The Dice score, intersection over union (IoU) and Cohen's κ were calculated against the ground truth annotations.



**Supplementary Figure 8. Visualizing the patch-level feature space.** To visualize the patchlevel feature space, for each task, we randomly sampled 2% of patches from each slide in the independent test cohort for a total of  $n = 54,995$ ,  $n = 64,687$  and  $n = 136,726$  patches for **a**) RCC, **b)** NSCLC and **c)** LN Met. Slides in the BWH independent test sets. We then reduced their 512 dimensional feature representations to two dimensions using PCA (**left**). For subtyping tasks (**a, b**), each patch is shaded with the class with the highest predicted probability (with  $p \ge 0.5$ ) by the clustering layers of the model. If a patch is predicted as negative ( $p < 0.5$ ) for all classes, it is labeled as "agnostic". We observe that patches predicted as different subtypes are separated into distinct clusters in the feature space, and patches sampled from each cluster generally exhibit morphology characteristic of each subtype. Similarly, for metastasis detection in axillary lymph nodes (c), patches are shaded as positive ( $p \ge 0.5$  for the positive class) and agnostic ( $p < 0.5$ ). The positive cluster generally picks out tumor cells and the agnostic cluster corresponds with immune cells and normal tissue.



#### **Supplementary Figure 9. CLAM model performance for different hyperparameter choices.**

Unless otherwise specified, we used a random validation fold from our 10-fold train/val/test partitions created for each task to tune for B, which controls the number of patches to consider for the task of instance-level clustering, and then *c*<sup>1</sup> and *c*2, which specify the relative contribution of the bag-level classification loss and the instance-level clustering loss in the total loss incurred for each slide during training (without loss of generality, we let  $c_2$  = 1 −  $c_1$  and tuned for different values of *c*1). The models were trained using 50% of cases in the training set corresponding the selected validation set. In each task, we did not notice a large difference in the validation performance for different hyperparameter choices.



**Supplementary Table 1. RCC subtyping: cross-validation performance on TCGA dataset.**  The 10-fold average performance (± std) in terms of test AUC, mean average precision score (mAP), F1 score and balanced accuracy score (bACC) are reported (n = 86). Macro-averaging is used for one-vs-rest AUC, F1 and mAP.



**Supplementary Table 2. NSCLC subtyping: cross-validation performance on TCGA + CPTAC dataset.** The 10-fold average performance (± std) in terms of test AUC, mean average precision score (mAP), F1 score and balanced accuracy score (bACC) are reported (n = 196).



**Supplementary Table 3. Lymph node metastasis detection: cross-validation performance on Camelyon16 + Camelyon17 dataset.** The 10-fold average performance (± std) in terms of test AUC, mean average precision score (mAP), F1 score and balanced accuracy score (bACC) are reported ( $n = 89$ ).

## **A. LN metastasis detection**



## **B. NSCLC subtyping**



# **C. RCC subtyping**



**Supplementary Table 4. Ablation experiments.** Experiments for CLAM with and without the clustering constraint were performed on the public dataset partitions (the same as our main study described by **Figure 2**) for all 3 disease models and different sized subsets of the full training set. The 10-fold mean test performance (± std) is reported for the AUC, bACC (balanced accuracy), F1 and mAP (mean average precision) score. For multi-class RCC subtyping, macro-averaging was used for all metrics to account for class imbalance. Clustering improves performance for smaller data denominations, particularly for more difficult tasks such as LN metastasis detection. Clustering also offers a mechanism of enhanced interpretability shown in **Supplementary Figure 8.** 

## **A. LN metastasis detection**



# **B. NSCLC subtyping**



## **C. RCC subtyping**



**Supplementary Table 5. Performance comparison with weakly-supervised baseline methods on public datasets using additional dataset partitions.** Additional experiments for comparing the performance of CLAM with weakly-supervised baseline algorithms trained using reduced data were performed on public datasets for all 3 disease models. Specifically, 40/10/50 and 60/10/30 train/val/test partitions were investigated on the same datasets used in our main cross-validation study (**Figure 2**)**.** These experiments have the additional benefit of allowing the algorithms to be assessed on larger held-out test sets (compared to *i.e.,* using 10% of the dataset as the test set). Consistent with the rest of our study, we used repeated 10-fold partitions for each task and the mean test performance (± std) is reported for the AUC, bACC (balanced accuracy), F1 and mAP (mean average precision) score. For multi-class RCC subtyping, macro-averaging was used for all metrics to account for class imbalance. We used the same hyperparameters for CLAM as in the main study and ablation experiments.

## **A. LN metastasis detection: Train C17 → Test C16 (n=399)**



## **B. NSCLC subtyping: Train TCGA → Test CPTAC (n=974)**



## **C. RCC subtyping: Train TCGA → Test TCGA (independent sites, n=140)**



**Supplementary Table 6. Additional performance comparison with weakly-supervised baseline methods on public datasets.** For NSCLC subtyping and lymph node met. detection, model development was performed using one dataset and evaluated on a separate dataset (*e.g.* train on TCGA data and test on CPTAC data). For RCC subtyping, 3 tissue source sites were selected to form an independent test set of 140 WSIs (19 Chromophobe, 23 Papillary, 98 Clear Cell) and the remaining of the TCGA dataset was used for model development. For each disease model, the data used for model development were randomly divided into a training (90% of cases) and validation (10% cases) set. Consistent with the rest of our study, we used a 10-fold partition for each task and the mean test performance (± std) is reported for the AUC, bACC (balanced accuracy), F1 and mAP (mean average precision) score. For multi-class RCC subtyping, macroaveraging was used for all metrics to account for class imbalance. We used the same hyperparameters for CLAM as in the main study and ablation experiments.



**Supplementary Table 7. Performance reported by related works.** For the Camelyon16 challenge, only the top 3 performing algorithms from the official leader board are included, full leader board can be accessed at: https://camelyon16.grand-challenge.org/Results/.



**Supplementary Table 8. Dataset summary.** Summary of all datasets used in the study.



**Supplementary Table 9. RCC subtyping performance evaluated on the BWH RCC independent test set.** The 10-fold average performance (± std) in terms of test AUC, mean average precision score (mAP), F1 score and balanced accuracy score (bACC) are reported (n = 135). Macro-averaging is used for one-vs-rest AUC, F1 and mAP.



**Supplementary Table 10. NSCLC subtyping performance evaluated on the BWH NSCLC independent test set.** The 10-fold average performance (± std) in terms of test AUC, mean average precision score (mAP), F1 score and balanced accuracy score (bACC) are reported (n = 131).



**Supplementary Table 11. Lymph node metastasis detection performance evaluated on the BWH lymph node independent test set.** The 10-fold average performance (± std) in terms of test AUC, mean average precision score (mAP), F1 score and balanced accuracy score (bACC) are reported ( $n = 133$ ).



**Supplementary Table 12. RCC subtyping: ensemble performance evaluated on the BWH RCC independent test sets.** For each slide, the predicted normalized scores from all 10 CLAM models developed on the TCGA training sets are averaged and used to inform the slide-level diagnosis. The ensemble performance is reported in terms of the macro-averaged test AUC, mAP and F1 score and balanced accuracy score (bACC). For individual subtypes, 95% confidence intervals for the per subtype one-vs-rest AUC were calculated using Delong's method and indicated in parentheses.



**Supplementary Table 13. NSCLC subtyping: ensemble performance evaluated on the BWH NSCLC independent test sets.** For each slide, the predicted normalized scores from all 10 CLAM models developed on the TCGA + CPTAC training sets are averaged and used to inform the slidelevel diagnosis. The ensemble performance is reported in terms of the average test AUC, mAP, F1 score and balanced accuracy score (bACC). The 95% confidence intervals for the true AUC were calculated using Delong's method and indicated in parentheses.



**Supplementary Table 14. Lymph node metastasis detection: ensemble performance evaluated on the BWH lymph node independent test sets.** For each slide, the predicted normalized scores from all 10 CLAM models developed on the Camelyon16 + Camelyon17 training sets are averaged and used to inform the slide-level diagnosis. The ensemble performance is reported in terms of the average test AUC, mAP, F1 score and balanced accuracy score (bACC). The 95% confidence intervals for the true AUC were calculated using Delong's method and indicated in parentheses.



**Supplementary Table 15. RCC subtyping performance evaluated on the BWH cellphone microscopy image test set.** The 10-fold average performance (± std) of CLAM models trained on TCGA are reported in terms of test AUC, mean average precision score (mAP), F1 score and balanced accuracy score (bACC) for n = 135. Macro-averaging is used for one-vs-rest AUC, F1 and mAP.



**Supplementary Table 16. NSCLC subtyping performance evaluated on the BWH cellphone microscopy image test set.** The 10-fold average performance (± std) of CLAM models trained on TCGA + CPTAC are reported in terms of test AUC, mean average precision score (mAP), F1 score and balanced accuracy score (bACC) for n = 131.





**Supplementary Table 17. Number of biopsy specimens embedded on BWH In-house biopsy** 

**slides.** The number of biopsy specimens embedded on each slide varies and ranges from 1 – 6 for lung biopsy WSIs and 1 - 5 for kidney biopsy WSIs. The median number of embedded specimens per slide is 2 for both datasets.



**Supplementary Table 18. RCC subtyping performance evaluated on the BWH RCC biopsy test set.** The 10-fold average performance (± std) of CLAM models trained on TCGA are reported in terms of test AUC, mean average precision score (mAP), F1 score and balanced accuracy score (bACC) for n = 92.



**Supplementary Table 19. NSCLC subtyping performance evaluated on the BWH NSCLC biopsy test set.** The 10-fold average performance (± std) of CLAM models trained on TCGA + CPTAC are reported in terms of test AUC, mean average precision score (mAP), F1 score and balanced accuracy score (bACC) for n = 110.



**Supplementary Table 20. Access links to public datasets used.**