

Exploring the Gastric Cancer Glycoproteome towards Glycan- targeted Chimeric Antigen Receptor (CAR)-T Cells Immunotherapy

Dylan Gomes Ferreira

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2025

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DYLAN GOMES FERREIRA

**EXPLORING THE GASTRIC CANCER GLYCOPROTEOME
TOWARDS GLYCAN-TARGETED CHIMERIC ANTIGEN RECEPTOR
(CAR)-T CELLS IMMUNOTHERAPY**

Tese de Candidatura ao grau de Doutor em Ciências
Biomédicas submetida ao Instituto de Ciências
Biomédicas Abel Salazar da Universidade do Porto.

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“Life will out...

The origins and lessons of life and evolution are long and complex but what they basically boil down to is... life will out... life will always find a way to continue... always... life will out...

This is a massive tumour ... look at its size... look at the way it invades healthy tissue... look at its vasculature. It's blood and tissue and flesh. It's growing, adapting to its environment, struggling to survive, to stay alive...

It's alive! We don't like to think of it that way, but it's nested in the womb of a human, feeding on its host, growing and fighting for life, almost like a fetus... let's just for science say, exactly like a fetus... because like a healthy fetus it is thriving...

It's gross right? That's the problem. Nobody wants something that nasty in their body. I would like you, for one moment, to consider the idea that to the tumour we are the problem... we are the invader, we are the danger... To the tumour we are the cancer! And the tumour? Well... the tumour sees itself as a sweet, cute, fat, cheek baby just trying to make its way into the world and we want to stop it... destroy it, tear it from its happy little home like barbarians. To the tumour we are the soulless murderous monsters! Why do I do this? Why do I call it baby and talk about killing it?... Because this kind of tumour deserves respect. He deserves a little humanity... It's not just a tumour... it's ingenuity... strength... adaptability... it's poetry... is one of God's masterpieces... it's alive!... and like any living thing, it wants to stay alive, like any living thing it's going to fight like hell to survive... it would rather destroy the human that holds it then go gently into that good night... into death... It's alive!

And once it all come down to?

Life will out!”

Amelia Shepherd

NOTA PRELIMINAR

Declaro que a presente tese é de minha autoria e não foi utilizada previamente noutro curso de outra instituição. As referências a outros autores (afirmações, ideias, pensamentos) respeitam escrupulosamente as regras da atribuição, e encontram-se devidamente indicadas no texto e nas referências bibliográficas, de acordo com as normas de referência. Tenho consciência de que a prática de plágio e auto-plágio constitui um ilícito académico.

Os trabalhos de investigação desta tese foram realizados no Grupo de Patologia e Terapêutica Experimental do Centro de Investigação do Instituto Português de Oncologia do Porto, EPE.

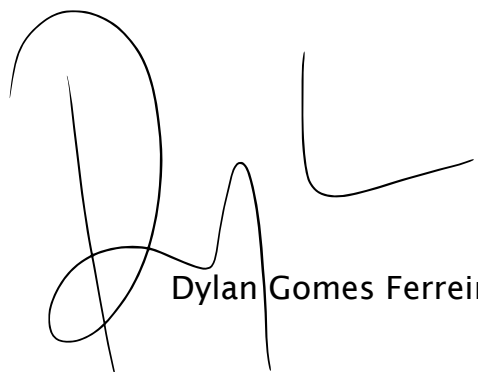
Declaro ainda que o presente trabalho foi financiado pela Fundação para a Ciência e a Tecnologia, pela atribuição de uma bolsa individual de doutoramento, com a referência 2020.09384.BD (doi: 10.54499/2020.09384.BD) com início em Janeiro de 2021 e término a Dezembro de 2024).

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Declaro que a presente tese é de minha autoria e não foi utilizada previamente noutro curso de outra instituição. As referências a outros autores (afirmações, ideias, pensamentos) respeitam escrupulosamente as regras da atribuição, e encontram-se devidamente indicadas no texto e nas referências bibliográficas, de acordo com as normas de referência. Tenho consciência de que a prática de plágio e auto-plágio constitui um ilícito académico. O artigo integralmente reproduzido nesta tese, no qual o candidato ao grau de Doutor é primeiro autor, encontra-se publicado em regime de acesso aberto ao abrigo da Licença *Creative Commons Attribution License* (<https://creativecommons.org/licenses/by/4.0/>) permitindo partilhar e adaptar os documentos para qualquer fim, mesmo que comercial, desde que seja atribuído o devido crédito ao autor, fornecida uma hiperligação para a licença, e indicando se foram feitas alterações. Mais declaro que não foram feitas alterações ao artigo já publicado.

Porto,



Dylan Gomes Ferreira

Em obediência ao disposto no nº 2 do Artigo 8º do Decreto-Lei nº 388/70, o autor declara que participou na conceção e na execução do trabalho experimental, bem como na interpretação dos resultados e na redação dos trabalhos a seguir referenciados, estejam estes já publicados ou em fase de publicação e que integram a tese aqui apresentada:

1. **Ferreira D.**, Marinho-Santos B., Relvas-Santos M., Orr B., Brandão A., Afonso LP., Santos LL., Ferreira JA. Trimmed *N*-Glycans Define Aggressive Gastric Cancer and Predict Clinical Outcomes. *Theranostics*. 2025. Impact factor: 12.4; Q1. doi: 10.7150/thno.111670

Authorship credit: conceptualisation, methodology, validation, investigation, resources, data curation, writing - original draft, visualization.

A presente publicação não foi, nem será, utilizada, parcial ou totalmente, em qualquer outra tese ou dissertação. Esta publicação foi integralmente incluída na presente tese, entre as páginas 41 e 118.

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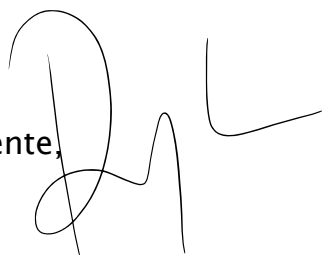
Aos meus amigos de infância e faculdade peço desculpa. Peço desculpa por tantos planos cancelados, por tantas ausências, por ter mergulhado no trabalho e dele não ter mais saído. Agradeço nunca me terem abandonado e terem sido um porto de abrigo seguro sempre que necessitava.

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Com os olhos mergulhados em lágrimas falta-me agradecer à génese. A quem motivou e me motiva a lutar diariamente para que outras famílias não sofram com o flagelo do cancro. É tempo de agradecer a si, madrinha, de quem sou orgulhosamente afilhado! Hoje não está cá para ler estas humildes palavras que lhe endereço, contudo não poderei deixar de deixar escrito em palavras a importância que teve e tem na minha vida. Foi abrigo nos dias de tempestade, foi farol nos dias de neblina, foi sol nos dias de celebração... foi “casa”. Se havia pessoa que era “casa”, era a minha madrinha... com o poder de um abraço conseguia acalmar tempestades e com um sorriso iluminar o dia. Era uma fortaleza, mesmo quando em si não havia mais força. Hoje fazem-me falta o seu sorriso, o seu abraço, a sua força, as suas palavras... faz-me falta! Palavras não bastarão para dizer o que significou, significa e sempre significará para mim. Por isso, lhe dedico esta humilde tentativa de melhorar um mundo ao qual já não pertence... Será para sempre o pedaço que falta em mim!

Sinceramente,

A handwritten signature in black ink, consisting of a large, stylized capital 'D' followed by a capital 'M' and a capital 'L'.

RESUMO

A incidência de cancro gástrico (CG) tem diminuído nos últimos anos, particularmente nos países desenvolvidos; no entanto, o CG continua a representar um importante desafio para a saúde pública a nível global. Cerca de dois terços dos doentes são diagnosticados com doença localmente avançada ou metastática, apresentando uma sobrevivência mediana inferior a 10 meses e uma taxa de sobrevivência aos 5 anos de aproximadamente 15%. Atualmente, os principais desafios na gestão de doentes com CG incluem a rápida progressão metastática e a eficácia limitada das terapias existentes, frequentemente associadas a efeitos secundários severos e debilitantes. Apesar dos esforços realizados, cerca de 50% dos casos de CG em estadio avançado tratados com quimioterapia convencional desenvolvem metástases à distância nos cinco anos seguintes ao diagnóstico. Para contrariar esta tendência, muitos estudos centram-se na identificação e correlação de alvos moleculares tumorais conhecidos com a carcinogénese e agressividade do CG, com o objetivo de melhorar as opções terapêuticas. Vários estudos investigam a glicosilação aberrante como um mediador importante na carcinogénese e agressividade do CG. Estudos funcionais sobre o impacto dos glicanos no processo de carcinogénese demonstraram que alterações na glicosilação de proteínas contribuem de forma decisiva para a definição de características oncogénicas chave. Globalmente, as alterações associadas ao cancro na glicosilação geram assinaturas moleculares únicas à superfície das células tumorais agressivas, apresentando um enorme potencial para o desenvolvimento de terapias direcionadas, como as células T com recetor quimérico de antigénio (*CAR-T cells*). Neste contexto, o nosso estudo multi-ómico dedica-se à exploração do glicocálix do CG, em especial do *N*-glicoma, com vista à identificação de assinaturas moleculares para tratamentos direcionados e medicina de precisão. O nosso estudo revelou um enriquecimento em paucimannoses, juntamente com uma diminuição na abundância relativa de *N*-glicanos

híbridos, em tumores mais agressivos e associados a pior prognóstico. A imunocoloração com a lectina *Galanthus nivalis* (GNL) confirmou que estes glicanos são específicos da doença, sendo raros na mucosa gástrica saudável, mas aumentando com a progressão do cancro. Além disso, demonstrou que a coloração por GNL em amostras de tecido superou os biomarcadores usados na clínica em termos de precisão prognóstica. Adicionalmente, encontramos uma correlação significativa entre a expressão destes *N*-glicanos truncados e glicosiltransferases e glicosidases específicas. Uma análise de larga escala com dados do TCGA relacionou ainda a expressão destas enzimas com fenótipos mais agressivos e piores prognósticos, reforçando a sua importância funcional na progressão do CG. De forma notável, estes *N*-glicanos truncados foram identificados predominantemente em proteínas ribossômicas intracelulares. Contudo, também identificámos as proteínas CEACAM6 e MMP9 como portadores destes *N*-glicanos, posicionando-os como alvos potenciais para terapias celulares direcionadas. A expressão de MMP9 demonstrou aumentar com o estadio e grau do tumor, e os tumores que coexpressavam MMP9 e paucimanoses estavam associados a pior prognóstico. Na análise ao soro, apenas a MMP9 apresentou potencial diagnóstico como biomarcador circulante, enquanto a expressão de ligandos de GNL não demonstrou associação significativa.

Em resumo, este estudo aprofunda o nosso conhecimento sobre o *N*-glicoma do cancro gástrico, destacando a relevância clínica de uma classe pouco explorada de glicanos – paucimanoses – e do glicoproteoma associado. Estes resultados abrem novas e promissoras perspectivas para estratégias terapêuticas mais precisas, em particular através do direccionamento da MMP9 paucimanosilada.

ABSTRACT

Gastric cancer (GC) incidence has declined in recent years, particularly in developed countries; however, GC remains a major global healthcare burden. Nearly two-thirds of patients are diagnosed with locally advanced or metastatic disease, with a median survival of less than 10 months and a 5-year overall survival rate of approximately 15%. Currently, key challenges in the management of GC patients include rapid metastatic progression and limited efficacy of existing therapies, which are often accompanied by severe and debilitating side effects. Despite extensive efforts, around 50% of advanced-stage GC cases treated with conventional chemotherapy develop distant metastases within five years of diagnosis. To overcome this tendency, many studies focus on disclosing and correlating the status of known tumour molecular targets with GC carcinogenesis and aggressiveness, aiming to improve therapeutic options. Several studies have investigated aberrant glycosylation as an important mediator of gastric carcinogenesis and aggressiveness. Functional studies about the impact of glycans in the carcinogenesis process have now demonstrated that alterations in protein glycosylation decisively contribute to defining key oncogenic features. Overall, cancer-associated changes in glycosylation are responsible for generating unique molecular signatures at the cell-surface of aggressive cancer cells, holding tremendous potential for developing targeted therapeutics, such as Chimeric Antigen Receptor T cells (CAR-T cells). In line with this, our multi-omics study devotes to the exploitation of GC glycocalyx, especially the *N*-glycome, towards the identification of molecular fingerprints for targeted treatment and precision medicine. Our study revealed an enrichment of paucimannosidic *N*-glycans, along with a decrease in the relative abundance of hybrid *N*-glycans in more aggressive tumours associated with poorer prognosis. Lectin immunostaining using *Galanthus Nivalis* Lectin (GNL) confirmed that these glycans were disease-specific, being rare in healthy gastric mucosa but increasing with cancer progression. Moreover, it showed that GNL staining in tissue samples

outperformed established biomarkers in prognostic accuracy. Additionally, we found a significant correlation between the expression of these trimmed *N*-glycans and specific glycosyltransferases and glycosidases. A large-scale TCGA analysis further linked the expression of these enzymes to more aggressive phenotypes and poorer prognoses, reinforcing their functional relevance in GC progression. Notably, these trimmed *N*-glycans were predominantly identified in intracellular ribosomal proteins. However, we also discovered CEACAM6 and MMP9 as carriers of these *N*-glycans, positioning them as potential targets for precise cancer cell targeting. MMP9 expression was shown to increase with tumour stage and grade, and tumours co-expressing MMP9 and paucimannosidic *N*-glycans were associated with the worst prognoses. In serum analysis, only MMP9 exhibited diagnostic potential as a circulating biomarker, whereas GNL-ligands expression did not show a significant association.

In summary, this study enhances our understanding of the gastric cancer glycome by highlighting the clinical significance of a previously underexplored class of glycans - paucimannosidic *N*-glycans - and their associated glycoproteome. These findings offer promising avenues for more precise therapeutic strategies, particularly targeting paucimannosylated MMP9.

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ABBREVIATIONS & ACRONYMS

ACRG: Asian Cancer Research Group
ADC: Antibody Drug-conjugate
AJCC: American Joint Committee on Cancer
AGC: Automatic Gain Control
AML: Acute Myeloid Leukemia
Asn: Asparagine
BSA: Bovine Serum Albumin
CagA: Cytotoxin-Associated Gene A
CAR: Chimeric Antigen Receptor
CDH1: E-cadherin
CIN: Chromosomal Instability
CSS: Cancer Specific Survival
DAPI: 4',6-Diamidino-2-phenylindole dihydrochloride
DTT: Dithiothreitol
EBV: Epstein-Barr Virus
ECF: Epirubicin, Cisplatin, 5-fluorouracil
ECM: Extracellular Matrix
EICs: Extracted Ion Chromatograms
EMT: Epithelial-to-Mesenchymal Transition
ER: Endoplasmic Reticulum
FFPE: Formalin-Fixed Paraffin-Embedded
Fuc: L-Fucose
Gal: D-Galactose
GalNAc: N-acetylgalactosamine
Glc: D-Glucose
GlcNAc: N-Acetyl-D-Glucosamine
GC: Gastric Cancer
GCC: Guanylyl Cyclase C
GDC: Genomic Data Commons

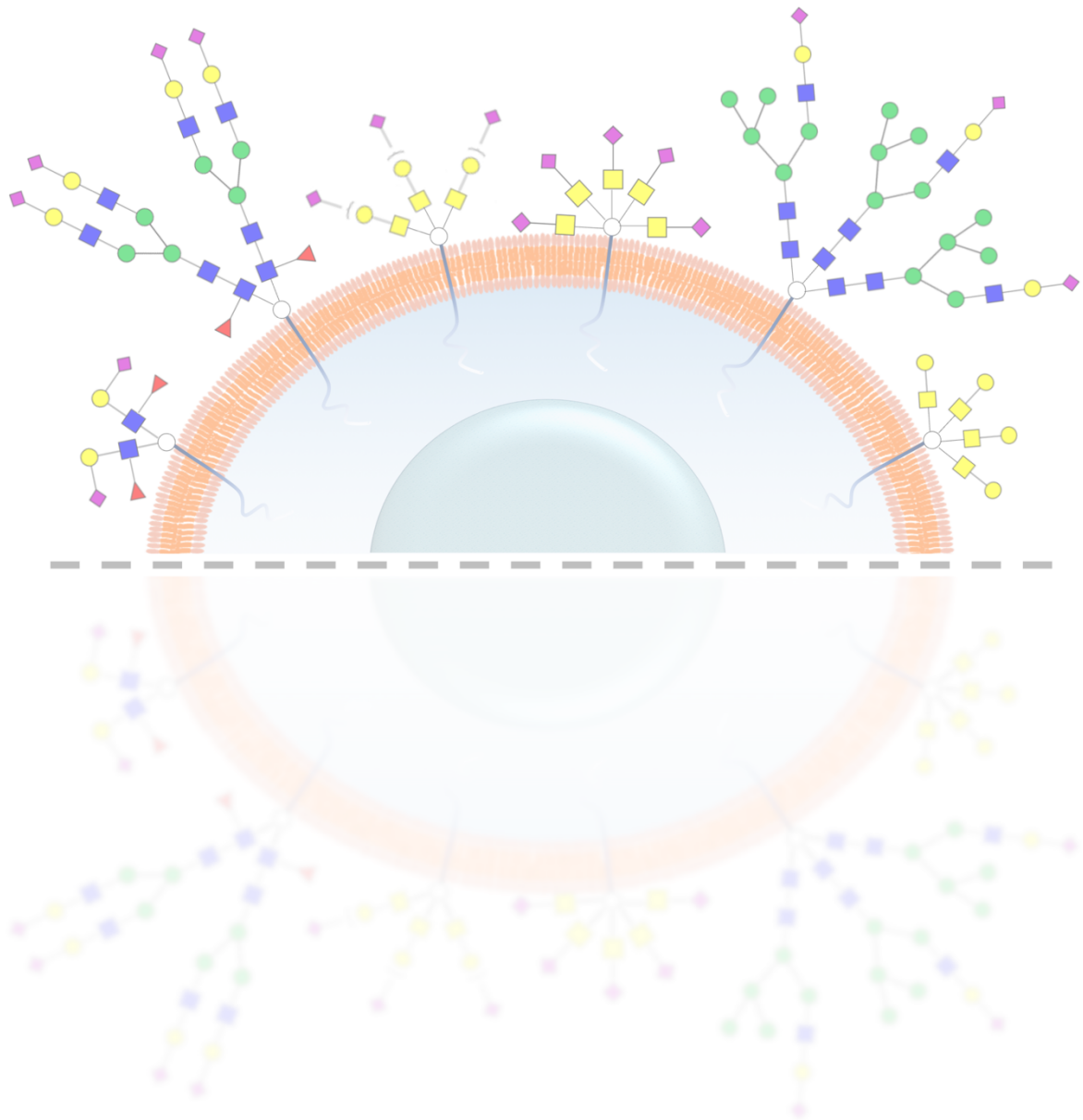
GIST: Gastrointestinal Stromal Tumours
GNL: Galanthus Nivalis Lectin
GO: Gene Ontology
GS: Genomically Stable
HCD: Higher energy Collisional Dissociation
Hex: *N*-acetyl- β -D-hexosaminidase
H. pylori: *Helicobacter pylori*
HPLC: High Performance Liquid Chromatography
IM: Intestinal Metaplasia
Man: D-Mannose
MSI: Microsatellite Instability
MSS: Microsatellite Stable
NCE: Normalized Collision Energy
OS: Overall Survival
PCAWG: International Cancer Genome Project's Pan-Cancer Analysis of Whole Genomes
PTM: Post-tranlation Modification
qPCR: Quantitative Polymerase Chain Reaction
RNA: Ribonucleic Acid
rRNA: Ribosomal Ribonucleic Acid
SabA: Sialic Acid-binding Adhesin
Ser: Serine
sLeA: sialyl Lewis A
sLeX: sialyl Lewis X
SPSS: Statistical Package for Social Sciences
sTn: sialyl-Tn
TCGA: The Cancer Genome Atlas
TD: Tumour Deposits
TFA: Trifluoroacetic Acid
Thr: Threonine
TMN: Tumour Node Metastasis
WHO: World Health Organization

THESIS OUTLINE

This thesis addresses main concerns associated with gastric cancer (GC) management, namely the lack of targetable molecules for developing innovative, less toxic and more effective therapeutics.

Cancer-associated altered glycosylation pathways translated by the overexpression of short-chain *O*-glycans and trimmed *N*-glycans offer an opportunity to improve GC patients' management, being the main area of focus in this thesis. The circumscribed expression of these aberrant forms of glycosylation in healthy tissues, together with its cell-surface localization, make them putative biomarkers for targeted therapeutics, such as Chimeric Antigen Receptor T cells (CAR-T cells).

Addressing these milestones, the present document is divided into four main sections: i) The **introduction (Section I)**, highlighting the main current clinical information about GC management, mainly through novel glycan-based therapeutic approaches; ii) The second segment, the **Aims and Scopes (Section II)**, summarize the main milestones and aims of the thesis, providing a detailed rationale and roadmap to establish aberrant glycosylation as a manner to improve GC management; iii) **Section III**, the **Results**, delivers a comprehensive view over the influence of trimmed *N*-glycans in GC aggressiveness, providing cues to include paucimannosylated glycoproteins in the design of novel therapeutic approaches for GC's management. This section is constituted by one published manuscript (**chapter 1**), presenting a multi-omics study visaging a detailed analysis over paucimannosidic *N*-glycans and its carriers, in order to identify putative biomarkers for GC; iv) Finally, **Section IV** presents the main **Concluding Remarks and Future Perspectives** foreseeing advances in GC patient's management.



INTRODUCTION

Gastric Cancer: Epidemiological Trends, Diagnostic and Therapeutic Frontiers, Emerging Opportunities

Gastric cancer (GC) is part of the top five most prevalent and deadliest worldwide. In 2022, almost 1 million new cases were diagnosed and at least 659,853 deaths were linked to this malignancy (1). Approximately half of GC patients develop metastasis within five years after surgery or experience severe treatment side effects, underscoring the disease's aggressive nature and its status as the fifth leading cause of cancer-related death globally, with a particularly high burden in Asia (1). Despite decades of effort - including widespread screening and intervention programs - GC remains a major healthcare challenge due to its complex molecular heterogeneity, which limits improvements in incidence and mortality rates (2-4). The limited molecular characterization of these tumours remains a significant challenge in patient management, particularly in the areas of early detection, treatment selection, patient stratification, and follow-up (4). Consequently, further studies aimed at elucidating the molecular phenotypes of GC are essential. Such research could pave the way for the development of novel classification systems, innovative screening programs, and more effective and safer therapeutic strategies (4).

Etiology and Pathogenesis

The primary driver of GC is persistent infection with *Helicobacter pylori* (*H. pylori*), which is implicated in about 60% of cases (5). Chronic *H. pylori* infection triggers a multistep cascade: Correa Cascade. It begins with chronic atrophic gastritis, progresses to intestinal metaplasia and dysplasia, and culminates in adenocarcinoma (6, 7). This pathway is especially relevant for the intestinal-type GC. In contrast, active and chronic gastritis -

regardless of *H. pylori* status - is the main risk factor for diffuse-type GC, which is more infiltrative and associated with a poorer prognosis (6-9).

While *H. pylori* infection is central, host factors also play a significant role. Genetic polymorphisms affecting molecules involved in bacterial adhesion, as well as variations in bacterial virulence genes, contribute to individual susceptibility (10-14). Additional risk factors include advanced age, poor diet, anemia, tobacco use, and alcohol consumption, all of which are established promoters of GC (15-21).

Histological and Molecular Classification

Generically, about 90% of GC cases are adenocarcinomas, with the remainder comprising lymphomas or gastrointestinal stromal tumours (GISTs). Most cases are sporadic, but familial clustering occurs in about 10%, and roughly 3% are hereditary (22).

In terms of etiology and molecular features, GC is a heterogeneous disease, yet main classification systems did not reflect this reality. Over past years, GC classification has evolved significantly, moving from purely histopathological and anatomical systems to the integration of molecular and genetic data (**Figure 1**). This shift aims to improve prognostic accuracy, guide therapeutic decisions, and support individualized patient management. However, refinement of main existent classification systems still required.

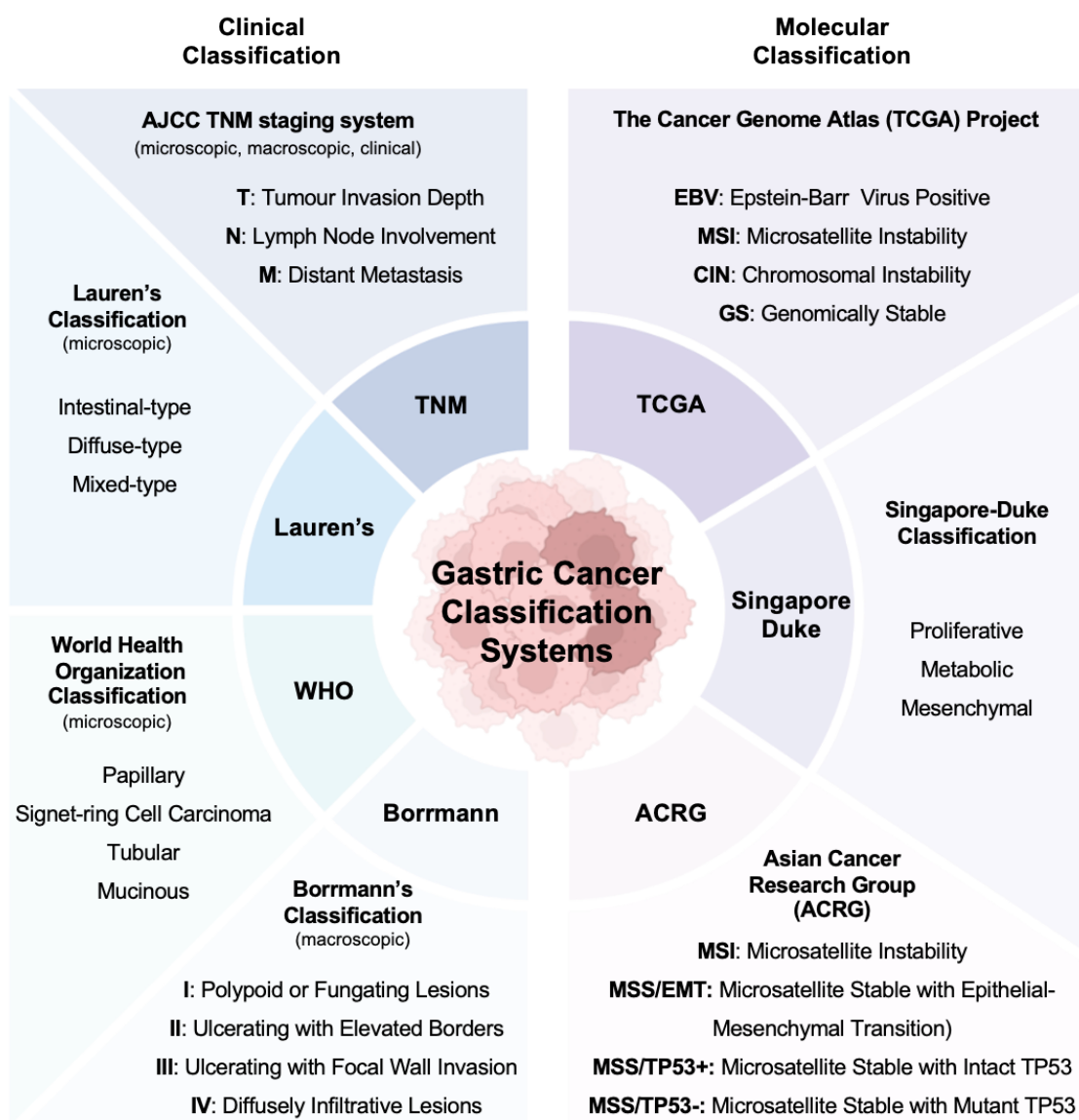


Figure 1. GC classification systems. Clinical classifications broadly used in routine practice (TNM, Lauren's, WHO, and Borrmann's) are based on histological and anatomical tumour features, as well as imaging findings. Conversely, molecular classification systems (TCGA, Singapore-Duke, and ACRG) rely on genomic and molecular characteristics, offering insights into tumour biology and potential therapeutic targets.

The tumour-node-metastasis (TNM) system remains the global benchmark for staging GC, focusing on tumour invasion depth (T), regional lymph node involvement (N), and distant metastasis (M) (23, 24). The 8th edition of the AJCC TNM staging system has sought to address prior limitations

concerning discrimination power, reproducibility, and staging homogeneity (25). However, challenges persist, particularly regarding inter-operator variability and data heterogeneity, which can introduce clinical bias (26). Notably, recent studies highlight the prognostic significance of tumour deposits (TDs) and suggest that integrating TD count with lymph node metastases may further refine the TNM system's prognostic accuracy (27).

Borrmann's classification, based on tumour gross appearance, remains widely used for advanced GC, dividing tumours into four types: Type I, polypoid or fungating lesions; Type II, ulcerating lesions with elevated borders; Type III, ulcerating lesions with focal wall invasion and Type IV, diffusely infiltrative lesions (linitis plastica) (28). Recent studies indicate that Borrmann types are associated with distinct clinicopathological and molecular features, such as age at diagnosis, tumour size, Lauren subtype, and microsatellite instability. However, Borrmann classification does not correlate with prognosis and lacks preoperative staging utility (28, 29).

Since the 1960s, Lauren's classification has been the cornerstone for histological subtyping, dividing GC into intestinal and diffuse types. Intestinal-type tumours are cohesive, glandular, and associated with intestinal metaplasia, generally conferring a better prognosis. Diffuse-type tumours are poorly cohesive, often with signet-ring cells, and are linked to peritoneal dissemination and worse outcomes (30-33). Recent advances have incorporated molecular markers such as Microsatellite Instability (MSI), Erbb2, E-cadherin, Fas and Bcl-XL expression, bridging Lauren's system with emerging molecular data (34).

The World Health Organization (WHO) classification, updated in 2019, further refines histological subtypes, including papillary, tubular, mucinous, and signet-ring cell carcinomas, and grades tubular adenocarcinomas by differentiation (35). The WHO classification has been remarkably useful in the management of patients with early-stage CG (36).

To enhance the GC classification, several reports have sought to integrate molecular insights into histological classification, aiming to improve patient stratification and optimize treatment selection (37). In line with this, The

Cancer Genome Atlas (TCGA) project has introduced a molecular taxonomy, categorizing gastric adenocarcinoma into four subtypes: Epstein-Barr virus-positive (EBV, ~9%); Microsatellite instability (MSI, ~22%); Genomically stable (GS, ~20%) and Chromosomal instability (CIN, ~50%) (38). Each subtype is associated with distinct genetic alterations and clinical features. For example, EBV-positive tumours show PIK3CA mutations and PD-L1/2 overexpression, while CIN tumours are enriched for TP53 mutations and receptor tyrosine kinase amplifications (38). Prognostically, EBV and MSI subtypes have better outcomes, while GS tumours fare worst. Importantly, CIN tumours benefit most from adjuvant chemotherapy, whereas GS tumours do not (38, 39) (40).

The Asian Cancer Research Group (ACRG) classification, especially relevant in Asian populations, divides GC into: MSI; MSS/EMT (microsatellite stable with epithelial-mesenchymal transition); MSS/TP53+ (microsatellite stable with intact TP53) and MSS/TP53- (microsatellite stable with mutant TP53) (41-43). The MSI group has the best prognosis and lowest recurrence, while the MSS/EMT group exhibits the poorest outcomes and highest recurrence (44). This system provides a framework for predicting prognosis and guiding therapy, though clinical implementation remains limited.

Singapore-Duke Classification system, based on molecular and biological properties, identifies three GC groups: Proliferative (often Lauren's intestinal type), Metabolic and Mesenchymal (correlates with Lauren's diffuse type and EMT features). The mesenchymal subtype is notable for stemness characteristics and sensitivity to PI3K-AKT-mTOR inhibitors, while the metabolic subtype responds better to 5-fluorouracil. However, survival differences among these subtypes are not significant, and clinical adoption is pending further validation (45).

Despite the proliferation of molecular classifications, their integration into routine clinical practice is still limited. Current systems often lack robust genetic-clinical associations and overlapping subtypes complicate risk stratification and treatment selection. Nevertheless, these molecular

insights are increasingly informing targeted therapy development (e.g., HER2 and VEGFR2 inhibitors for CIN and MSI subtypes) (46). Future research should aim to harmonize histological and molecular data, incorporate proteomic and transcriptomic profiles, and validate predictive biomarkers for therapy selection. The goal is a unified, clinically actionable classification system that enables precision oncology for GC patients.

GC Management and Challenges

GC incidence, especially in developed countries, has declined in recent years (1). However, advances in patient treatment have been limited, largely due to the molecular complexity and heterogeneity of gastric tumours. While less invasive treatment options are being explored, surgery remains the cornerstone for managing early-stage gastric cancer, representing the most effective curative approach. For mucosa-confined and non-ulcerated or non-infiltrated early-stage tumours, endoscopic resection can be considered, allowing for the removal of tumours with minimal invasiveness (47). However, advanced tumours, especially those with an infiltrative phenotype, often require more aggressive interventions. Advanced gastric tumours typically require a multidisciplinary approach that combines surgery, radiotherapy, and several chemotherapy modalities. In patients with resectable tumours, perioperative chemotherapy - such as the ECF regimen (epirubicin, cisplatin, and 5-fluorouracil) - has demonstrated a significant improvement in 5-year survival rates compared to surgical resection alone (36.3% vs. 23%, respectively) (48). Additionally, both adjuvant and postoperative chemotherapy can further enhance overall survival for patients with resectable localized tumours (49-51). However, despite these advances, more than 50% of early-stage gastric cancer patients experience local relapse or distant dissemination (52). Accurate staging and appropriate therapeutic strategies are critical to improving outcomes for these patients.

Standard treatment for advanced gastric cancer involves chemotherapy, often using agents such as platinum compounds, fluoropyrimidines, topoisomerase inhibitors, or anthracyclines. However, the effectiveness of these regimens is limited by poor patient tolerance, suboptimal dosing, and the absence of a clear definition for first- and second-line therapies. Factors such as comorbidities, organ dysfunction, and performance status further complicate treatment decisions (47, 53-55). Combining several chemotherapeutic agents may improve outcomes but also increases toxicity (56, 57). Despite ongoing research, about 50% of patients with advanced gastric cancer develop distant metastases within five years of diagnosis, and many succumb to the disease within this period (58, 59). The lack of effective targeted therapies underscores the urgent need for novel treatment alternatives, especially those based on a deeper understanding of GC biology. Recent efforts have focused on molecular targets such as EGFR, MET, ERBB2/HER2, and the PI3K/AKT/mTOR pathways (60). For instance, targeting HER2 with trastuzumab has shown promise in selected patients with HER2-positive tumours (61).

In summary, while progress has been made in the management of GC, significant challenges remain. Improving early detection, refining multimodal treatment strategies, and developing effective targeted therapies are essential to enhance patient outcomes and survival rates. Moreover, it is essential to develop stratification systems to guide treatment decisions.

Glycosylation: An Avenue towards GC Management

Gastric carcinogenesis is a complex and multidimensional process that is not fully understood, highlighting the need for integrating different omics approaches for deeper insights and more precise patient management. Nonetheless, several studies have focused on glycosylation as a critical mediator of GC development.

Glycosylation, a non-genetically encoded protein modification, represents one of the most abundant post-translational modifications (PTMs), occurring on secreted and transmembrane proteins, as well as lipids at the cell surface (62). The synthesis of sugar chains is a complex process orchestrated by nucleotide sugar transporters, glycosyltransferases, and glycosidases within the cytoplasm, more specifically in the endoplasmic reticulum (ER) and Golgi apparatus. This biosynthetic pathway results in two primary classes of glycans: *O*-glycans, attached to serine (Ser) or threonine (Thr) residues, and *N*-glycans, linked to asparagine (Asn) moieties in polypeptide chains (**Figure 2**) (63, 64). The Tn antigen, a simple monosaccharide synthesized in the ER by ppGalNAc-Ts, represents the basic form of protein *O*-glycosylation. This structure can be extended by T-synthase to form the disaccharide T antigen, also known as the Thomsen-Friedenreich antigen. Both T and Tn antigens can undergo sialylation by sialyltransferases, producing sialyl-T, disialyl-T, and sialyl-Tn (STn) antigens, which prevent further elongation or processing (63). In contrast, *N*-glycosylation initiates in the ER with the addition of a precursor glycan to asparagine (Asn) residues within Asn-X-Ser/Thr peptide sequence (where X represents any amino acid except proline), representing a more intricate process than *O*-glycosylation. Simplifying, the action of an array of glycosyltransferases and glycosidases give rise to different class of *N*-glycans, including oligomannoses, complex *N*-glycans, hybrid *N*-glycans and paucimannosidic *N*-glycans (64).

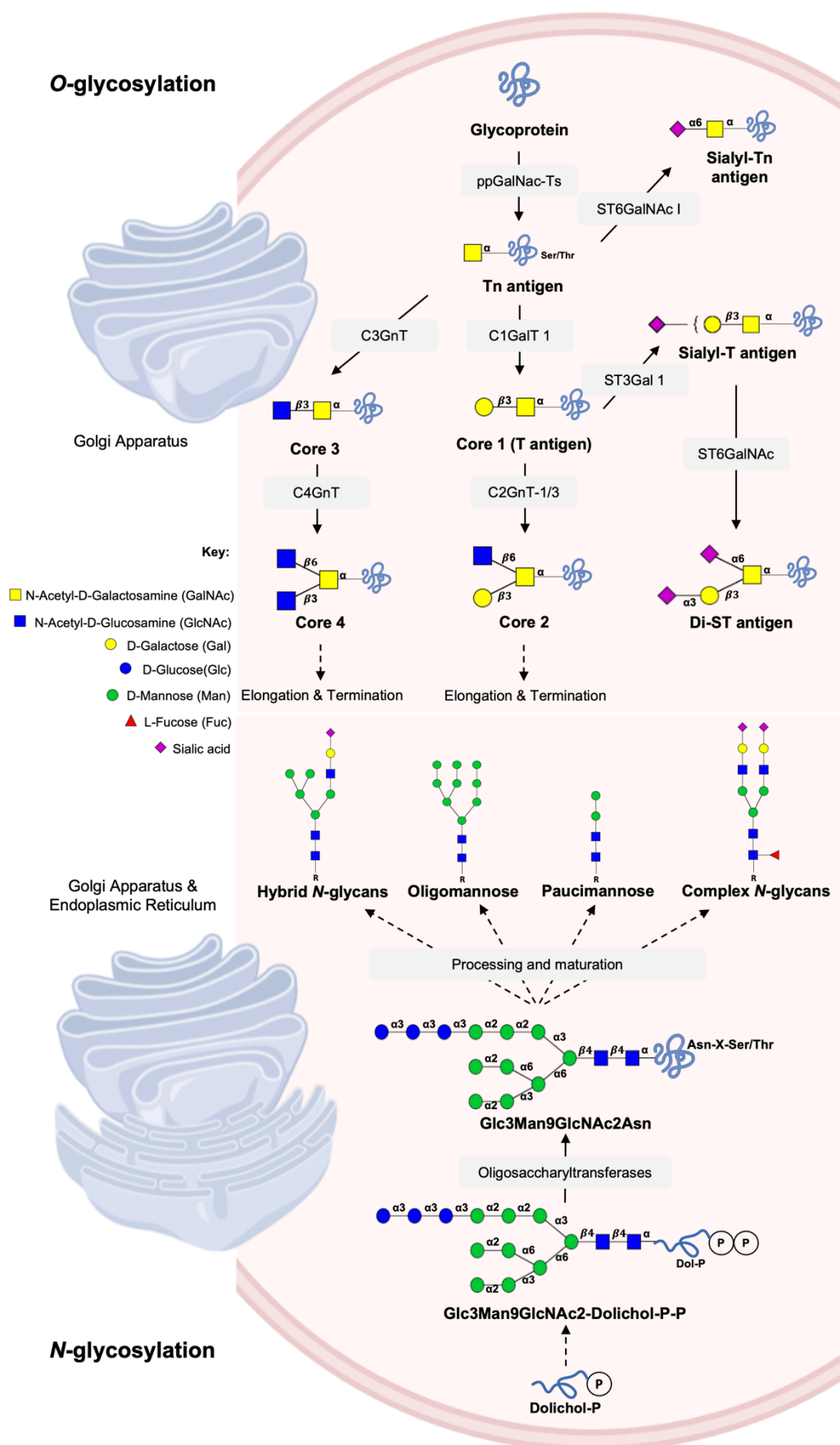


Figure 2. Comprehensive overview of glycan biosynthetic pathways involved in protein

glycosylation. Mucin-type *O*-glycan biosynthesis begins either in the ER or within the Golgi apparatus through the action of polypeptide GalNAc-transferases, which add *N*-acetylgalactosamine (GalNAc) to serine or threonine residues on proteins, resulting in the formation of the Tn antigen. The Tn antigen can be converted into the sTn form by the enzyme ST6GalNAc I, which prevents further glycan extension. Alternatively, C1Gal-T1 can extend the Tn antigen into the core 1 structure (T antigen), which may then be capped with sialic acid residues by ST3Gal I, generating sialyl T or disialyl T antigens—again halting further extension. The T antigen can also be further modified into a core 2 structure by C2GnT-I or III. In addition, the Tn antigen can be converted into core 3 by C3GnT, and subsequently into core 4 through the action of C4GnT. These extended *O*-glycans may display elongated and terminal motifs such as sialyl Lewis antigens. *N*-glycan synthesis is initiated at the membrane of the endoplasmic reticulum (ER), where Glc₃Man₉GlcNAc₂-P-P-Dol is transferred to asparagine (Asn) residues within the Asn-X-Ser/Thr motif of proteins by the enzyme oligosaccharyltransferase (“X” denotes any amino acid except proline). Following this initial step, *N*-glycans undergo processing in the ER, and the resulting glycoproteins exit toward the Golgi apparatus carrying oligomannose-type *N*-glycans composed of eight or nine mannose units. In the medial-Golgi, hybrid and complex *N*-glycan forms are synthesized, characterized by branching GlcNAc additions, core sugar modifications, and the incorporation of terminal sugar residues. These terminal modifications include structures such as sialyl Lewis antigens. Additionally, trimming of oligomannose-type *N*-glycans can lead to the formation of paucimannosidic *N*-glycans.

Paucimannosidic *N*-glycan, truncated/trimmed *N*-glycan structures, have emerged as significant players in human biology, particularly within the immune system and, more recently, in cancer. However, its biosynthetic pathway and biological relevance remain to be fully elucidated. Recently, a few reports have attempted to uncover its importance in disease contexts and identify the key players involved in its synthesis. Ugonotti et al. demonstrated that *N*-acetyl-β-D-hexosaminidases (Hex) mediate the formation of paucimannosidic *N*-glycans in human neutrophils via a noncanonical truncation pathway. Disruption of HEXA and HEXB, which encode Hex subunits, significantly reduced paucimannosylation in neutrophil-like cells, indicating the importance of these enzymes in

paucimannose biosynthesis (65). The implications of paucimannosidic *N*-glycans extend to disease states. Indeed, Thaysen-Andersen et al. found that neutrophils secrete bioactive paucimannosidic proteins into the sputum of lungs undergoing pathogen-based inflammation, suggesting a role in the immune response (66). Further, Chatterjee et al. expanded the scope by showing that protein paucimannosylation is a molecular feature of several human cancers, with paucimannose levels often elevated in tumour compared to non-tumour tissues (67). These findings highlight the importance of paucimannosidic *N*-glycans in both immunity and cancer; however, no reports have identified putative carriers in GC or explored their functional role in GC carcinogenesis. Further research is needed to fully elucidate the biosynthetic pathways, regulatory mechanisms, and functional roles of paucimannosidic *N*-glycans in these contexts, potentially leading to novel diagnostic and therapeutic strategies. Both *O*- and *N*-glycans can display Lewis blood group-related antigens (LeA, LeX, LeB, and LeY) and their corresponding sialylated forms, such as sLeA (64).

Molecular Foundations of Glycan Targeting

Aberrant glycosylation in GC generates tumour-associated carbohydrate antigens that serve as both biomarkers and therapeutic targets (68, 69). Glycans on the cell surface mediate various cellular functions, including cell adhesion, motility, immune evasion, growth factor receptor regulation, and the attachment of *H. pylori* to the epithelium (70-72). Aberrant glycosylation patterns are frequently observed in solid tumours, including GC (72-74), and even in precursor lesions like intestinal metaplasia (IM) (75).

A hallmark of GC is the aberrant *O*-glycosylation, notably the overexpression of immature structures such as the Tn and sialyl-Tn (sTn) antigens, resulting from premature truncation of mucin-type *O*-glycans (76). These structures impair cell-cell adhesion, enhance tumour cell motility, and facilitate

immune escape by engaging inhibitory receptors on immune cells (77-79). Concurrently, GC exhibits marked oversialylation of both *N*- and *O*-glycans, promoting oncogenic signaling pathways including c-Met, RON, and ErbB receptors, and correlating with enhanced metastatic potential (80-82). Modifications of the *N*-glycome are increasingly recognized in GC, including the upregulation of highly branched, sialylated glycans that mediate interactions with selectins and contribute to metastasis (70, 81, 83-86). Core-fucosylation is often downregulated, with emerging evidence suggesting that restoration of core fucose may suppress tumour growth (87, 88). Reports on bisecting GlcNAc structures remain conflicting - some studies associate their expression with tumour suppression - underscoring the complexity of glycosylation dynamics in GC (81, 85, 89, 90). While truncated *O*-glycans are well studied, immature *N*-glycan structures such as paucimannoses, which have been implicated in immune modulation and metastasis in other cancers, remain virtually unexplored in GC. Despite the recognized clinical significance of glycan alterations, current research often focuses on isolated glycan classes or glycoproteins, limiting a comprehensive understanding of glycosylation changes in GC (91).

GC cells often overexpress sialylated antigens like sLeA, sLex, and sTn, which correlate with unfavorable patient prognoses, being typically absent or minimally expressed in healthy tissues (74, 92, 93). For instance, sLeA correlates with larger tumour size and deeper invasion (94). Additionally, dimeric sLeA/X act as E-selectin ligands, facilitating tumour cell intravasation into blood vessels and the arrest of circulating tumour cells in distant organs during hematogenous dissemination (95-97). Interactions between sLeA and extracellular matrix proteins in blood vessels enhance tumour cell extravasation to metastatic sites (98). SLeA and sLeX also serve as ligands for the bacterial sialic acid-binding adhesin (SabA), promoting *H. pylori* adhesion to the gastric mucosa, a key carcinogenic agent (76). In GC cells, sLeA is primarily carried by the ErbB2 tyrosine kinase receptor, leading to ErbB2 hyperactivation and concomitant activation of oncogenic signaling pathways (80). These findings suggest a critical role for sialyl Lewis antigens

in tumour aggressiveness, highlighting their prognostic and predictive value in GC. Additional modulation of *O*-glycosylation pathways in cancer cells can result in the neo- or overexpression of sTn antigen (99-102). STn overexpression is observed in several epithelial cancers, including GC (103), and its role in carcinogenesis has been extensively studied in the last decade. STn overexpression in GC is associated with increased invasion depth, advanced tumour stage, venous and lymphatic dissemination, and reduced overall survival (92, 93, 104). Moreover, subsequent studies using glycoengineered cell lines overexpressing ST6GalNAc-I, primary enzyme controlling sTn expression in gastrointestinal tissues, have demonstrated sTn's functional impact in cancer, as sTn is rarely overexpressed in cell culture (77, 100, 101, 105). Overexpression of ST6GalNAc-I and sTn in GC cells influences cell cycle, apoptosis, adhesion, motility, invasion, and metastasis (77, 100, 106). *In vitro*, sTn-expressing cells show reduced cell-cell aggregation but increased adhesion to ECM components like collagen and fibronectin (77). Transfected cells also display lower proliferation rates, although not due to G1 cell cycle arrest. Moreover, sTn overexpression in GC cells alters galectin-3 localization, increasing intracellular accumulation and decreasing interaction with cell surface glycan receptors, leading to chemoresistant phenotypes (77, 107). *In vivo* studies show that glycoengineered cancer cells overexpressing sTn exhibit increased metastatic potential and reduced survival rates (106). Like sLeA, sTn overexpression impacts ErbB2 and EGFR activation in GC cells, implicating *O*-glycan truncation in the constitutive activation of oncogenic signaling pathways (100). These findings emphasize sTn's critical role in acquiring oncogenic phenotypes related to migration, invasion, and chemoresistance, consistent with reports from other tumours (bladder, ovarian, prostate, breast) (108-110). In conclusion, functional glycobiology studies have demonstrated that alterations in *O*- and *N*-glycome significantly contribute to key oncogenic features such as the activation of oncogenic pathways, cell motility, invasion, immune evasion, chemoresistance, and tumour dissemination (**Figure 3**) (72, 111).

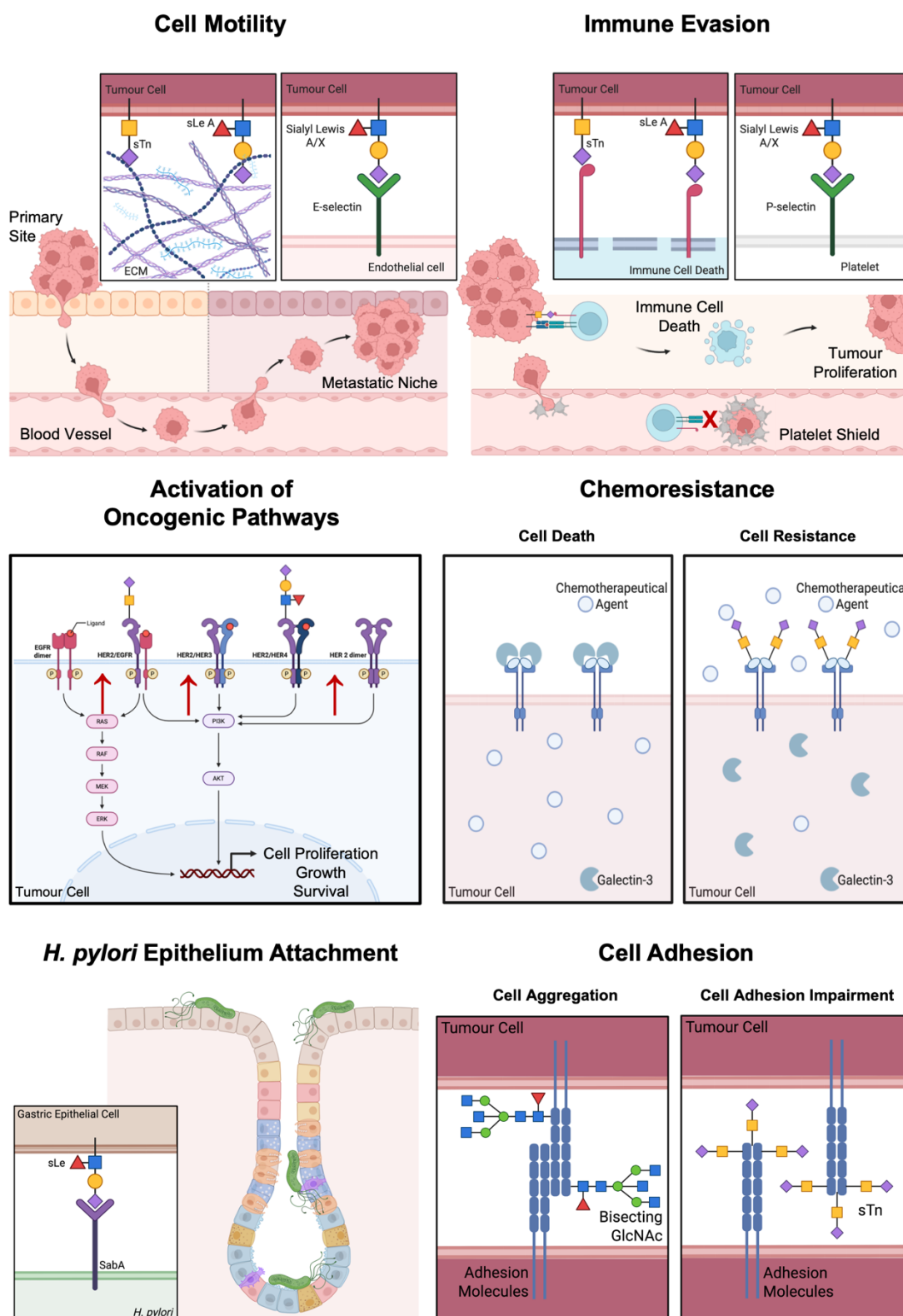


Figure 3. Functional impact of protein glycosylation on GC progression. *O*- and *N*-glycans play a critical role in several oncogenic features of GC, including, cell motility, immune evasion, activation of oncogenic pathways, chemoresistance, *H. pylori* gastric

colonization and impaired cell adhesion. Glycans such as sTn and sLeA/X are key mediators of tumour migration, intravasation and extravasation by interacting with extracellular matrix (ECM) components and E-selectin (expressed on the surface of endothelial cells). Moreover, sialylated glycans, such as sLeA, contribute to immune evasion by promoting apoptosis or by facilitating the formation of a platelet shield around circulating tumour cells. SLeA also plays a pivotal role in the colonization of gastric mucosa by *H. pylori*, binding to SabA (sialic acid-binding adhesin) present in the bacteria. Cell overexpressing sialylated forms of Tn or Lewis A antigens show enhanced activation of key oncogenic pathways, resulting in increased proliferation, growth and tumour cell survival. Additionally, cells with elevated sTn expression exhibit greater resistance to chemotherapy, attributed to Galectin-3 subcellular delocalization and reduced cell adhesion. Conversely, certain glycans structures, such as bisecting GlcNAc, are essential to the proper assembling of adherens junctions and maintaining normal cell-cell adhesion.

Nonetheless, comprehensive and integrative glycomic and glycoproteomic profiling are essential to elucidate the evolution of glycosylation changes during disease progression and identify putative carriers.

A key focus in GC research has been the regulation of E-cadherin (CDH1), including by glycosylation. E-cadherin is a transmembrane protein essential for cell-cell adhesion and maintaining tissue architecture (112). Its downregulation, mutation, or inactivation triggers a cascade of events that disrupt cellular interactions and gastric tissue structure, thereby promoting GC development. Indeed, dysregulation of E-cadherin is closely associated with poor clinical outcomes in GC (113, 114). Aberrant E-cadherin expression arises from genetic, epigenetic, and post-translational modifications (70%), with *N*-glycosylation playing a particularly critical role (113). The extracellular domain of E-cadherin, essential for its function, contains four potential *N*-glycosylation sites: Asn554, Asn566, Asn618, and Asn633. These sites are crucial for proper protein folding, expression, and function (115, 116). Specifically, the absence of *N*-glycosylation at Asn633 leads to E-cadherin ubiquitination and degradation (116). The interaction between E-cadherin and p120 catenin, a key regulator of E-cadherin endocytosis and stability, is also modulated by E-cadherin's *N*-glycosylation

status. Glycosylation by GnT-III, which introduces bisecting GlcNAc structures, stabilizes E-cadherin at the cell surface and prevents its internalization. This stabilization strengthens cell–cell adhesion and inhibits intracellular signaling pathways involved in cell motility, invasion, migration, and epithelial–mesenchymal transition, thereby suppressing tumour progression (117-119). Conversely, β 1,6 GlcNAc branched structures in E-cadherin destabilize E-cadherin at the cell surface, disrupting the cadherin–catenin complex. This disruption impairs GC cell aggregation and contributes to a less cohesive, more invasive phenotype (120). Therefore, E-cadherin expression in gastric cancer should be carefully evaluated. Functional impairment may present not as complete loss of expression, but as a redistribution of the protein from the membrane to the cytoplasm. This underscores the need for integrative studies encompassing both glycome and glycoproteome analyses, for a comprehensive evaluation of other potential targets in GC (91). Such efforts hold great promise for improving biomarker discovery, patient stratification, and the development of glycan-targeted therapeutic strategies in GC.

Glycan-based Targeted Therapeutics for Cancer

Glycan-based targeted therapeutics represent a paradigm shift in GC treatment, leveraging tumour-specific glycosylation patterns to overcome chemotherapy resistance, metastasis and severe therapeutic side effects. Recent advances integrate glycoproteomic insights with bioengineering to develop precision interventions, though clinical translation faces multifaceted challenges. Nonetheless, aberrant glycosylation patterns in GC cells create unique molecular fingerprints exploitable for precision therapies, with main approaches showing pre-clinical and clinical potential being Antibody-Drug Conjugates (ADCs) and CAR-T cells.

Recent advances in ADC therapies for GC have highlighted several promising targets and positive pre-clinical and clinical outcomes. The TRA-1-60 antigen, targeted by the Bstrongomab-MMAE conjugate, demonstrated a significant 52% reduction in peritoneal carcinomatosis in HSC-58 xenograft models, suggesting potent anti-tumour activity (121). In parallel, targeting sLeA with ARX788, an anti-HER2 ADC, achieved a 37.9% overall response rate in patients with HER2-positive advanced GC during a Phase I clinical trial, emphasizing the therapeutic potential of HER2-directed approaches beyond traditional monoclonal antibodies (122). Despite more modest results, TAK-164 (5F9-DGN549), an ADC targeting guanylyl cyclase C (GCC) receptors, demonstrated limited clinical efficacy with a median progression-free survival of 44 days; however, it maintained a manageable toxicity profile, supporting the feasibility of further optimization (123).

CAR-T cell therapy is a promising anticancer treatment that uses the host's immune system to fight cancer by modifying immune cells to express an artificial receptor (CAR) that targets cancer-specific markers (124). CAR-T cell therapy has shown encouraging results in hematologic malignancies; however, it remains challenging to treat solid tumours due to the lack of cancer-specific molecular targets and the immunosuppressive tumour microenvironment (125-127). The ideal target for CAR-T cell therapy is a molecule specifically expressed at the cellular surface of neoplastic cells, which is essential for cancer development and progression. Although numerous candidates exist, few antigens meet the requirements for successful CAR-T cell therapy, especially in solid tumours. On this sense, aberrant tumour cell surface glycome provides a rich source of potential targets for novel CAR formulations. Multiple glycoantigens, including truncated *O*-glycans and sialylated structures, have been exploited for the development of glycan-directed CAR-T cells. Several approaches, including lectin- and antibody-based detection and mass spectrometry-based glycomics and glycoproteomics, have enabled the identification of these tumour-associated glycoepitopes. A study identified scFv variants with higher affinity for the Tn epitope, allowing genetic modification of T cells

with novel glycan-directed CARs, demonstrating strong cytotoxic responses against mouse and human cancer cell lines defective in *O*-linked glycosylation (128). The STn antigen represents another ideal candidate for CAR-T cell therapy, depicting high tumour specificity and association with glycoproteins like TAG72, commonly overexpressed by different cancer types. Preclinical models have demonstrated that anti-TAG72 CAR-T cells mediate robust tumour cytotoxicity and inhibit tumour expansion (129); however, clinical studies have reported heterogeneous clearance rates and impaired trafficking to metastatic sites (130). Cell surface hypersialylation is a common feature of tumour cells, supporting an immunosuppressive microenvironment. Incorporating sialic acid-binding domains from siglecs in CAR constructs allows genetically modified T cells to detect and eliminate cancer cells displaying cell surface sialoglycan antigens (131). Ganglioside-targeted CAR-Ts, such as those against GD2, have been developed for neuroblastoma treatment, improving survival rates and leading to tumour regression and necrosis in early-phase clinical trials (NCT03356782, NCT03635632 and NCT04539366) (132, 133). The Ley tetrasaccharide antigen, despite residual expression in healthy tissues, is a suitable target candidate for CAR-T cells due to its aberrant overexpression on the surface of cancer cells of epithelial-derived tumours. CAR-T cells targeting Ley have demonstrated cytokine production, proliferation, and tumour inhibition in preclinical models (134). A Phase I clinical trial in patients with acute myeloid leukemia (AML) reported partial remissions and evidence of CAR-T cell trafficking to the bone marrow (135). Ongoing clinical trials are further investigating Ley-directed CAR-T therapies: NCT03198052 and NCT03851146. MUC1, a transmembrane glycoprotein overexpressed in most carcinomas, is aberrantly glycosylated and enriched in Tn- and STn-containing glycopeptides. CAR-T cells targeting the cancer-associated Tn and STn antigens bound to MUC1 have shown specific binding and inhibited tumour growth in xenograft models (136). Their efficacy is currently under investigation in two clinical trials: NCT03525782 and NCT03633773.

However, the efficacy of these strategies remains below the desired level, mainly due to low tumour infiltration. To enhance CAR-T cell homing and tissue infiltration, glycoengineering approaches have been developed. Specifically, engineering CAR-T cells to express sialyl Lewis x (sLex) motifs enables interaction with endothelial selectins, mimicking physiological leukocyte trafficking during inflammation. In preclinical studies, sLex-engineered CAR-T cells demonstrated improved bone marrow infiltration following systemic administration (137).

Despite the promising preclinical success of glycan-targeted therapeutics, clinical translation faces significant hurdles. The intrinsic complexity of glycan synthesis continues to complicate scalable production of ADCs and nanoparticles (138). Furthermore, immune modulation poses another challenge, once sialic acid-Siglec-7/9 interactions suppress CD8⁺ tumour-infiltrating lymphocyte infiltration, an effect that can be mitigated by co-delivery of PD-L1 inhibitors (139). Finally, most biomarker validations have been confined to cell lines and *ex vivo* models, urging the need for multi-omics studies to confirm the translational relevance of glycan targets in human gastric tumours.

Looking ahead, next-generation strategies are poised to reshape the field. Switchable ADCs, such as pH-sensitive anti-STn conjugates releasing SN-38 selectively in metastatic niches, represent a paradigm shift toward precision delivery (69). Glyco-immunotherapy approaches, exemplified by STn-pulsed dendritic cell vaccines combined with anti-GD2 CAR-T cells (NCT0488859), are advancing rapidly and may overcome tumour immune evasion mechanisms (68).

In conclusion, advances in glycoproteomics and bioengineering are critical to refine glycan-based targeting, offering a path toward personalized therapies for advanced GC patients. While glycan-based therapies require optimization of delivery kinetics and combinatorial regimens, they represent a strategic frontier for managing advanced GC's molecular complexity.

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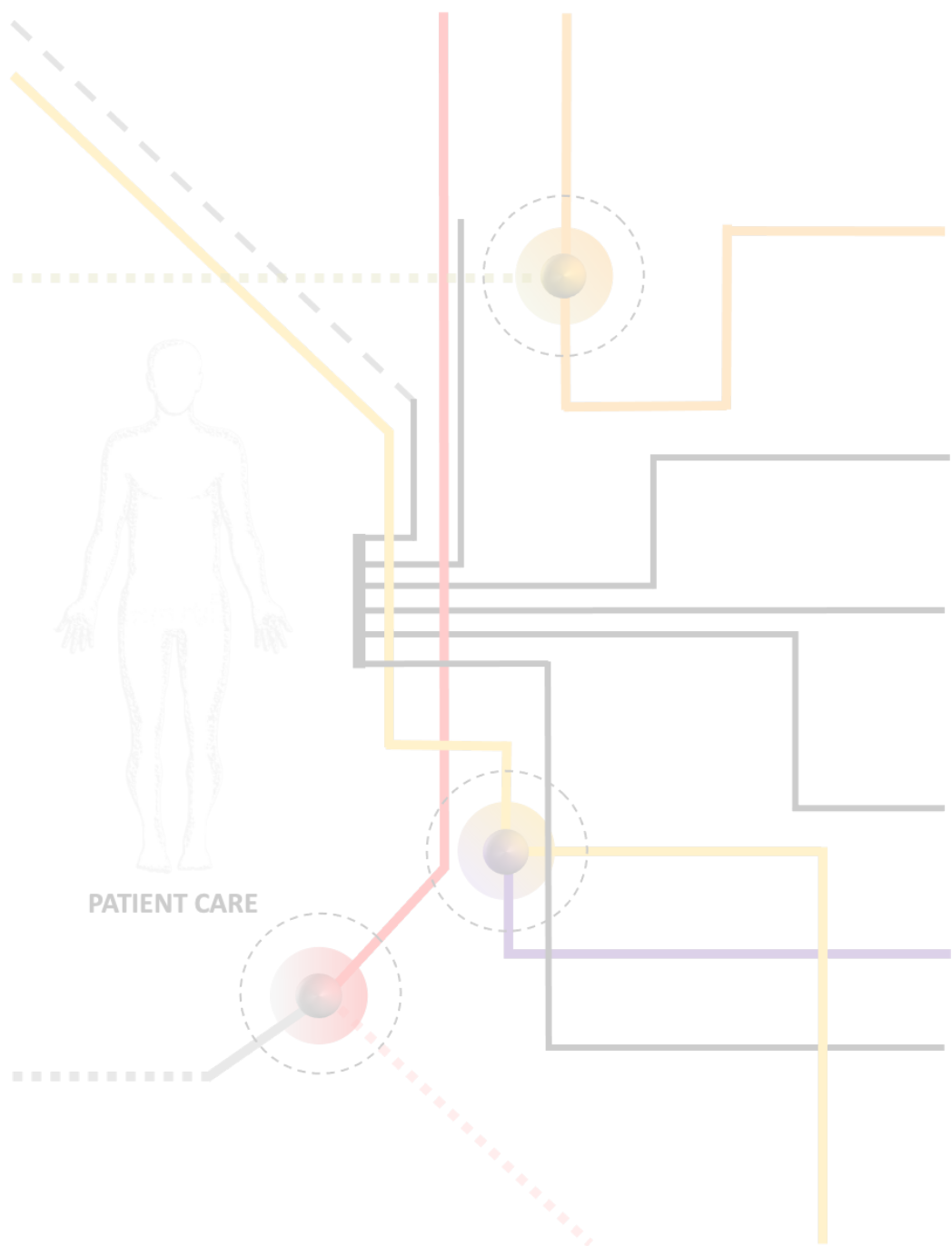
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STUDY OUTLINE & AIMS

Study Outline & Aims

GC is one of the deadliest cancers worldwide, accounting for over a million diagnosed cases per year and 768.793 deaths in 2020 (1). The high mortality rate primarily due to late diagnosis and molecular heterogeneity, which hinder the development of novel therapeutical approaches. Moreover, 50% of GC patients develop metastasis within 5 years after treatment, with a median survival of no more than 10 months. Conventional therapy often fails to improve these outcomes (2), highlighting the urgent need to identify biomarkers linked to disease progression for precise cancer control. Altered protein glycosylation, a key driver of several cancer hallmarks, holds great potential for precision oncology. These cancer-associated glycosylation signatures have functional impacts on cell invasion and tumour dissemination, making them promising biomarkers for management of GC patients (3, 4).

Accordingly, the following specific aims have been established, emphasizing *N*-glycosylation as a promising avenue toward precision medicine.

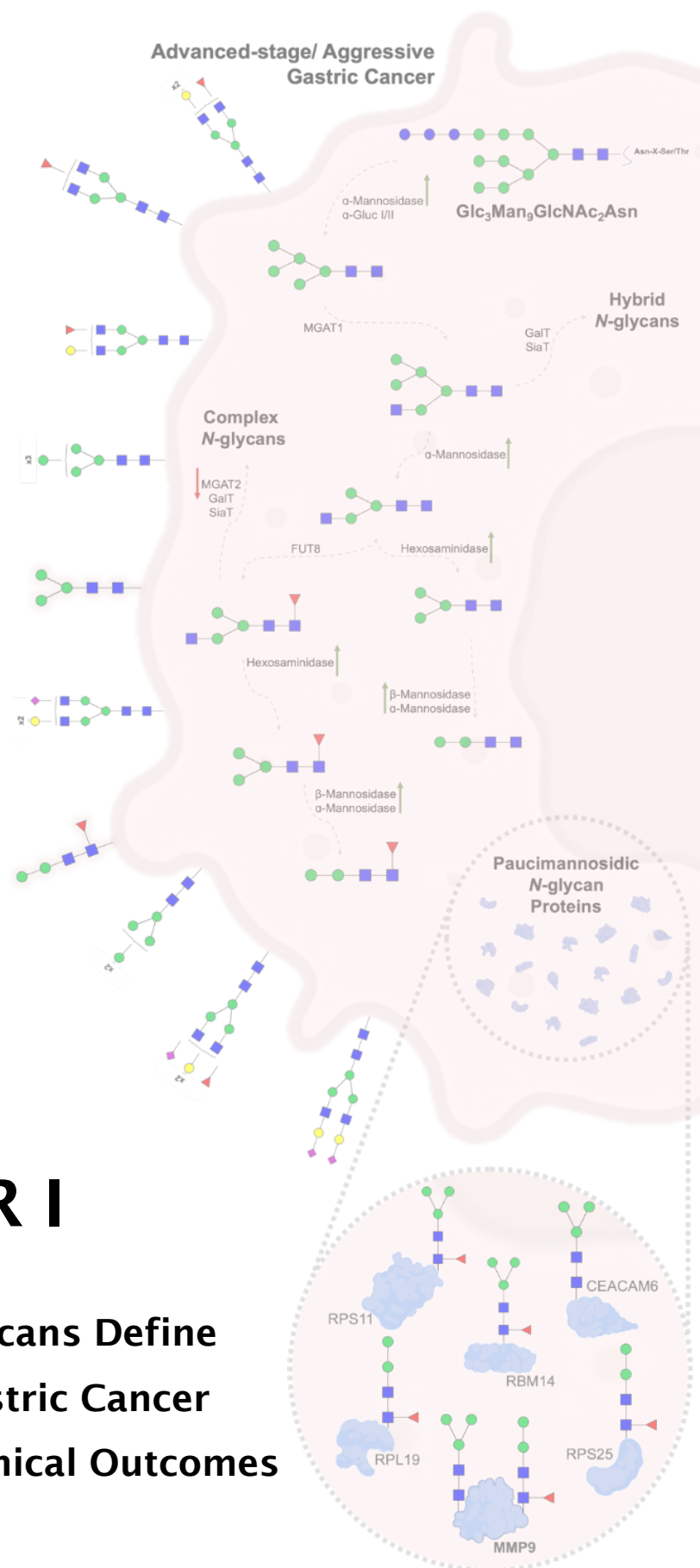
- i) Assess the under-characterized GC glycocalyx and identify specific *N*-glycan signatures linked to cancer aggressiveness through high-throughput *N*-glycan analysis by mass spectrometry, thereby improving management strategies for advanced-stage GC patients.
- ii) Characterise the *N*-glycoproteome in gastric tumour tissues, with an emphasis on paucimannosylated glycoproteins, aiming to identify putative biomarkers of aggressive GC forms.
- iii) Clinically validate GC-specific glycoproteomic signatures, laying the groundwork for the development of glycopeptide libraries for future targeted therapies.

Briefly, the project aims to translate different levels of technology readiness in glycomics, proteomics, glycoproteomics, transcriptomics and bioinformatics towards the identification of relevant cancer-specific glycobiomarkers in GC.

Chapter I presents a pan-omics study focused on identify putative carriers of paucimannosidic *N*-glycans, delivering a comprehensive overview of significant remodeling of the glycocalyx on gastric tumour cells throughout disease progression. It offers an in-depth interrogation of these glycan carriers and integrates the overexpression of paucimannosylated glycoproteins within the clinical context, offering key insights into their potential role in cancer progression. Altogether, this work identifies tumour glycophenotypes that could substantiate the development of glycan-based therapies aimed at selectively treating aggressive forms of GC. Ultimately, it is expected to contribute to improved quality of life and survival for GC patients.

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CHAPTER I

Trimmed N-Glycans Define Aggressive Gastric Cancer and Predict Clinical Outcomes

The information provided in this chapter presents part of published data of a manuscript by Dylan Ferreira et al.
This chapter is based in the following published data:

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Trimmed *N*-Glycans Define Aggressive Gastric Cancer and Predict Clinical Outcomes

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Running Title: Trimmed *N*-Glycans as Biomarkers of Aggressive Gastric Cancer

Abstract

Rationale: Gastric cancer (GC) is a leading cause of cancer-related mortality, particularly in advanced stages where prognosis and targeted treatment remain challenging. The glycocalyx, a dense network of glycans and glycoproteins, is critical for tumor progression and immune evasion, yet its molecular signatures are poorly understood. This study investigates glycan-based biomarkers of aggressiveness, focusing on paucimannosidic *N*-glycans, a previously underexplored glycosylation pattern in cancer.

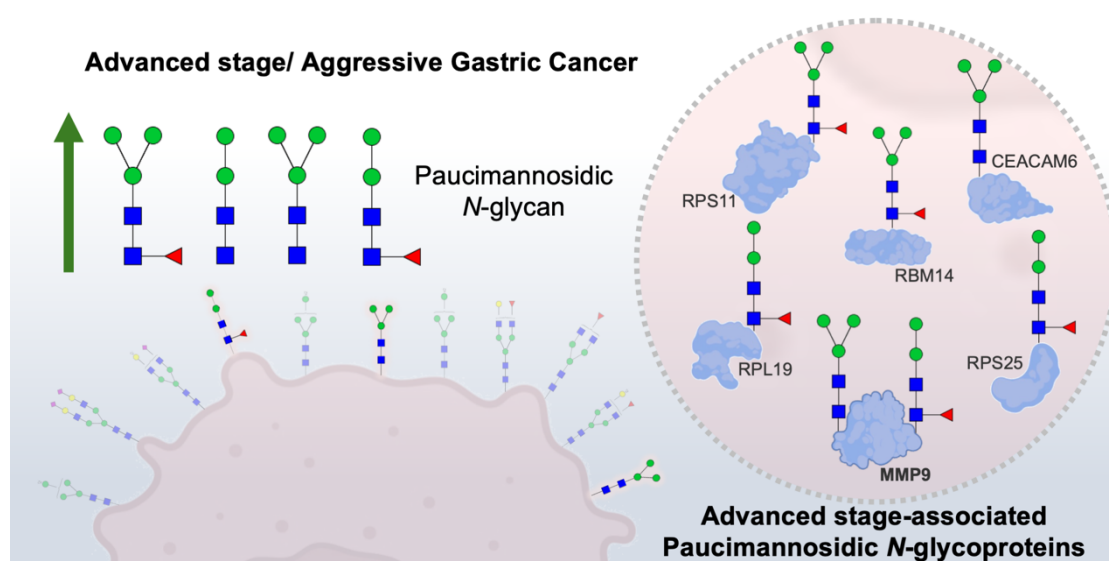
Methods: High-throughput *N*-glycome analysis was performed on gastric tumors of varying aggressiveness, followed by *Galanthus Nivalis* Lectin (GNL) immunostaining to assess paucimannosidic glycans across tumor stages. Comparative analysis was performed against clinically relevant GC biomarkers (E-cadherin, p53, MSI, sTn, sLeA). TCGA analysis correlated key paucimannose-associated glycosyltransferases with clinical outcomes. Glycoproteomics identified glycoproteins carrying paucimannoses, later validated using immunoassays in tumor tissues for clinical relevance. Additionally, serum samples were analyzed to evaluate the non-invasive potential of GNL reactivity and associated glycoproteins.

Results: Aggressive gastric tumors were significantly enriched in paucimannosidic *N*-glycans, a feature not previously reported in this malignancy. Lectin immunoblotting confirmed their disease specificity, with expression increasing with tumor progression. GNL staining outperformed established biomarkers in prognostic accuracy. TCGA analysis of more than 400 cases showed a strong correlation between high paucimannose-associated glycosyltransferase expression and poor prognosis. Glycoproteomics unexpectedly revealed paucimannose *N*-glycans primarily on intracellular ribosomal proteins, though key membrane proteins like MMP9 displayed aberrant paucimannosylation. MMP9 expression increased with tumor stage and grade, with tumors co-expressing MMP9 and paucimannosidic glycans exhibiting the worst prognosis. In serum, only

MMP9 demonstrated diagnostic potential as a circulating biomarker, whereas GNL did not show a significant association.

Conclusions: This study provides the first comprehensive characterization of the GC glycome, linking paucimannosidic *N*-glycans to tumor aggressiveness and poor clinical outcome. These glycans demonstrated superior prognostic performance compared to established clinical biomarkers. Their association with MMP9 further suggests a key role in disease progression. Together, these findings suggest that alterations in *N*-glycosylation, including paucimannosylated glycoproteins, hold promise for future prognostic and therapeutic applications in gastric cancer.

Keywords: cancer glycobiology, precision oncology, gastric cancer, glycoproteome, glycome



Introduction

Gastric cancer (GC) remains a significant global health challenge due to its aggressive progression and poor prognosis, particularly in advanced stages [1, 2]. This underscores the critical need for reliable biomarkers to support accurate patient stratification and targeted therapeutic interventions.

The glycocalyx, a dense layer of glycoproteins, glycolipids, and glycosaminoglycans on the cell surface, plays crucial roles in cell signaling, adhesion, and protection against microenvironmental stress [3, 4]. Notably, aberrant glycosylation is now recognized as a hallmark of cancer, driving tumor progression through dysregulated receptor signaling, immune evasion, and metastatic dissemination, while offering valuable insights for clinical decision-making [5-7]. Furthermore, alterations in glycosylation often lead to disease-specific glycoproteoforms that are localized on the cell surface, holding potential as therapeutic targets [8-12]. Namely, it has long been established that advanced tumours overexpress short glycans such as the Tn and sialyl-Tn (sTn) antigens, resulting from premature truncation of mucin-type *O*-glycosylation [13]. These aberrant *O*-glycans contribute to tumour progression by disrupting cell-cell adhesion and promoting immune evasion through interactions with inhibitory receptors on immune cells [14-16]. More recently, growing evidence has highlighted that *N*-glycans, typically known for their elongated and branched structures, can also exist in truncated forms, such as paucimannose-type glycans [17]. Paucimannoses, are a subset of trimmed glycans, are simplified *N*-glycans composed of 1–3 mannose residues attached to the conserved GlcNAc₂ core, with or without a fucose residue. These glycans arise due to altered activity of Golgi mannosidases and deficient elongation by *N*-acetylglucosaminyltransferases, leading to stalled glycan maturation [17-19]. Unlike complex *N*-glycans, trimmed glycans such as paucimannoses lack extensive branching and terminal decorations, reflecting incomplete

glycosylation processes [20, 21]. Paucimannoses have been observed in various tumor types, including colorectal [22], renal [23], lung [23], and glioblastoma cancers [24]. High levels of paucimannosylation correlate with poor prognosis in advanced colorectal cancer [25]. Functionally, paucimannose-type *N*-glycans are recognized by innate immune lectins such as DC-SIGN and the mannose receptor, which can trigger tolerogenic signaling in dendritic cells and macrophages, contributing to immune suppression [19, 23, 26]. Additionally, these glycans influence the trafficking and stability of surface proteins like integrins and growth factor receptors, promoting cell migration, invasion, and increased resistance to apoptotic cues.

In GC, specific glycosylation changes have been identified as key drivers of cancer progression. These include immature Tn and sTn antigens, as well as oversialylation found in more extended *N*- and *O*-glycans found in other solid tumours [13, 27]. These modifications enhance tumor cell adhesion, migration, immune evasion, and activate oncogenic pathways such as c-Met, RON, and ErbB receptor signaling [28-30]. Furthermore, these glycan changes are associated with poor prognosis, with some, like sialyl Lewis A (CA19-9) and sTn (CA72-4), already used as serological biomarkers for clinical monitoring of disease and recurrence [31-34]. Notably, while alterations in *O*-glycosylation have been widely reported in GC, the *N*-glycome remains comparatively less explored, with many aspects of its functional relevance still unclear. Nevertheless, emerging glycomics studies have begun to shed light on specific alterations, such as the increased expression of branched *N*-glycans, which are closely associated with enhanced tumour invasiveness and metastatic potential [35-39]. These structures are frequently terminated with sialic acids, giving rise to sialylated Lewis antigens, which mediate metastasis and contribute to GC's aggressiveness [29, 35]. Additionally, core-fucosylated *N*-glycans have been found to be downregulated in GC, with studies suggesting that their restoration may inhibit tumour cell proliferation [40, 41]. However, the complexity of GC's glycome is exemplified by contrasting reports on *N*-

glycan alterations. While earlier studies describe increased expression of bisecting GlcNAc structures, recent research indicates the opposite, with their overexpression potentially exerting tumour suppressive effects [29, 38, 42, 43]. Also, immature *N*-glycan structures such as paucimannoses remain virtually uncharacterized in GC, despite being increasingly recognized in other tumour types. These findings underscore a critical gap in our understanding of the *N*-glycome in GC. Despite growing evidence of glycan alterations, most studies have focused on isolated glycan classes or relied on single analytical approaches, failing to capture the full complexity and dynamic nature of glycosylation [44]. As a result, the contribution of the glycome to cancer progression and metastasis across disease stages remains largely unresolved. Addressing this requires systematic and integrative glycomic profiling. Equally important is the characterization of the glycoproteome, as the functional impact of glycosylation depends on the specific proteins modified and their cellular context. Glycoproteomics enables the identification of proteins carrying aberrant glycosylation and allows site-specific mapping of glycosylation patterns, revealing functionally relevant glycoproteoforms linked to tumour biology. Integrating glycomic and glycoproteomic data can improve biomarker specificity and therapeutic targeting, paving the way for more precise strategies in gastric cancer [44, 45]. Addressing this gap, we aim to provide a comprehensive characterization of the GC *N*-glycome and glycoproteome, focusing on their evolution during disease progression. By enhancing our understanding of glycocalyx alterations, we seek to uncover molecular insights that improve patient stratification and inform the development of novel therapeutic strategies for GC.

Methods

Patient Sample Set

Galanthus Nivalis Lectin (GNL) reactivity, E-cadherin, Sialyl-Tn (sTn), Sialyl-Lewis A (sLeA), p53 protein and Microsatellite Instability (MSI) were

retrospectively analysed in 148 formalin-fixed paraffin-embedded (FFPE) primary gastric tumour tissues obtained from the IPO-Porto biobank, reflecting two distinct clinical stages [early-stage (I/II) versus advanced-stage (III/IV) GC]. Early-stage cases were typically characterized by localized disease (T1-T2, N0/N1, M0), while advanced-stage includes cases with deeper invasion ($\geq$ T3), lymph node involvement ($\geq$ N2), or distant metastasis (M1), following the American Joint Committee on Cancer 8th edition criteria [46]. Moreover, cases were classified according with the size of the tumor (T), the involvement of nearby lymph nodes (N), and the presence of distant metastasis (M), based on TNM classification system [46]. The patient sample set included 66 female and 82 male patients, aged between 34 and 89 years (average age: 64 years), who underwent gastrectomy at IPO-Porto from 2004 to 2016. A subset of 30 out of 148 FFPE primary gastric tumour tissues was selected for analysis of MMP9 expression levels. Additionally, both MMP9 and GNL staining were analysed in 10 FFPE lymph nodes metastases in an independent sample set of 5 male and 5 female patients, aged between 39 and 85 years (median age: 56 years). All clinicopathological information used to assess clinical relevance is summarized in **Table 1, 2 and 3**. Clinicopathological data were extracted from the patients' medical records. This study received approval from the IPO institutional Ethics Committee (Approval No. CES 87/017) and was conducted following informed written consent from all participating patients. All study methodologies were performed according to the standards set by the declaration of Helsinki. A series of healthy tissues recovered from autopsies, including colon, pancreas, stomach, skin, testis, spleen and thyroid were also screened for these antigens to assess cancer specificity.

Table 1. Clinicopathological data of patients included in the analysis of GNL and classical biomarkers in GC primary tumors (n = 148).

	<i>n</i> (%)
Male	82 (55)
Female	66 (45)
Stage	
I	13 (9)
II	52 (35)
III	61 (41)
IV	22 (15)
Primary tumor (T)	
T1	10 (7)
T2	13 (9)
T3	87 (59)
T4	37 (25)
Missing information	1 (0)
Regional lymph nodes (N)	
N0	42 (28)
N1	32 (22)
N2	20 (14)
N3	53 (36)
Missing information	1 (0)
Distant metastasis (M)	
M0	115 (77)
M1	23 (16)
Missing information	10 (7)
Lauren's classification	
Intestinal type	101 (68)
Diffuse-type	29 (20)
Mixed	14 (9)
Missing information	4 (3)
Age (average, min-max)	64 years (34-89)

Table 2. Clinicopathological data of patients included in the analysis of MMP-9 in GC primary tumors (n = 30).

	<i>n</i> (%)
Male	17 (57)
Female	13 (43)
Stage	
I	10 (33)
II	4 (13)
III	5 (17)
IV	11 (37)
Primary tumor (T)	
T1	7 (23)
T2	6 (20)
T3	16 (54)
T4	0 (0)
Missing information	1 (3)
Regional lymph nodes (N)	
N0	9 (30)
N1	8 (27)
N2	3 (10)
N3	9 (30)
Missing information	1 (3)
Distant metastasis (M)	
M0	16 (53)
M1	11 (37)
Missing information	3 (10)
Age (average, min-max)	60 years (37-75)

Table 3. Clinicopathological data of patients included in the analysis of GNL-ligands and MMP-9 in GC lymph nodes metastasis (n = 10).

	<i>n</i> (%)
Male	5 (50)
Female	5 (50)
Stage	
II	1 (10)
III	7 (70)
IV	2 (20)
Primary tumor (T)	
T2	1 (10)
T3	1 (10)
T4	8 (80)
Regional lymph nodes (N)	
N1	1 (10)
N2	0 (0)
N3	9 (90)
Distant metastasis (M)	
M0	7 (70)
M1	3 (30)
Age (average, min-max)	56 years (39-85)

Mass Spectrometry-assisted N-Glycomics

N-glycomics was performed on 13 FFPE GC tissue samples based on methods previously described by Zhang T and Madunic K *et al.* [47]. Samples for analysis were elected by a certified pathologist after confirming tumor content and excluding necrotic or poorly preserved areas. Clinicopathological data of patients included in the N-glycomics analysis is summarized in **Table 4**. Briefly, FFPE tissues were deparaffinized, rehydrated, and subjected to heat-induced antigen retrieval using a citrate-based solution (Vector Laboratories). Then, proteins were denatured and reduced by incubation with 150 μ L denaturation mix [145 μ L of 8 M GuHCl and 5 μ L of 200 mM dithiothreitol (DTT)] at 60 °C for 30 min. N-glycan

release was achieved after digestion with PNGase F (1 U/10 µg protein at 37 °C overnight; Promega). Released *N*-glycans were hydrolyzed with 25 µL of 100 mM ammonium acetate at pH 5 (1 h at RT), removing the glycosylamine form of the non-reducing terminus, and subsequently reduced with 20 µL of 1 M NaBH₄ in 50 mM KOH (3 h at 50 °C). The reaction was quenched by adding glacial acetic acid. Then, *N*-glycan samples were desalted using a cation exchange resin (AG 50W-X8; Bio-Rad). Finally, reduced *N*-glycans were permethylated and analyzed by reverse phase nanoLC-ESI-MS/MS as previously described by us [48], using a Vanquish neoUHPLC nano-LC coupled to a QExactive Plus mass spectrometer (Thermo Fisher Scientific). Eluent A was aqueous formic acid (0.1%) and eluent B was formic acid (0.1%) in 80% acetonitrile. Samples were injected directly into a trapping column (PEPMAP NEO C18, 5 µm particle size 300 µm × 5 mm) and separated in the analytical column (EASY-Spray C18 PepMap, 100 Å, 150 mm × 75 µm ID and 3 µm particle size) at a flow rate of 0.25 µL/min. Column temperature was set at 35 °C. Permethylated glycan separation occurred using a multistep linear gradient to obtain 12% eluent B at 10 min, 45% eluent B at 20 min, 60% eluent B at 55 min and 99% eluent B at 65 min. The column was maintained at 99% eluent B for 10 min before re-equilibration at 5% eluent B. The mass spectrometer was operated in the positive ion mode, with an *m/z* range from 500 to 4000 with 140k resolution (Full MS), a spray voltage of 1.9 kV, and a transfer capillary temperature of 275 °C. Tandem MS (MS/MS) data were acquired using a data-dependent method with dynamic exclusion of 5.0 s at a 17,500 resolution. The top 15 most intense ions were selected for higher energy collisional dissociation (HCD), using 10% normalized collision energy (nce), and an isolation window of 4.0 *m/z*. Data were recorded with Thermo Scientific Xcalibur software version 4.5. Instrument performance during nanoLC-MS/MS was monitored using repeated injections of bovine serum albumin (BSA) tryptic digests to ensure consistency. Glycan identifications were validated through MS/MS fragmentation patterns, and specificity was confirmed using PNGase F-treated control samples. To further assess analytical reproducibility,

selected samples were reinjected and reanalyzed after three months of dry storage at -20°C in sealed tubes, yielding consistent glycan profiles with a coefficient of variation (CV) below 10%, confirming method stability. Glycan structures were identified considering previous knowledge on glycosylation, chromatography retention times, and m/z identification, assisted by the GlycoWorkbench version 2.1 [49]. The relative abundance resulted from the sum of the extracted ion chromatogram areas for each glycan structure in relation to the sum of chromatographic areas of all identified glycans.

Table 4. Clinicopathological data of patients included in *N*-glycomics analysis (n = 13).

	<i>n</i> (%)
Male	10 (77)
Female	3 (23)
Stage	
I	6 (46)
II	0 (0)
III	5 (39)
IV	2 (15)
Primary tumor (T)	
T1	4 (31)
T2	3 (23)
T3	5 (39)
T4	0 (0)
Missing information	1 (7)
Regional lymph nodes (N)	
N0	4 (31)
N1	3 (24)
N2	1 (7)
N3	4 (31)
Missing information	1 (7)
Distant metastasis (M)	
M0	10 (77)
M1	2 (15)
Missing information	1 (8)
Age (average, min-max)	59 years (36-75)

Glycoproteomics

GC samples analyzed by *N*-glycomics (12 out of 13) were submitted to lectin-based enrichment to identify putative carriers of paucimannosidic *N*-

glycans. Briefly, samples were deparaffinized with heptane and rehydrated, followed by protein extraction using Qproteome FFPE tissue kit (Qiagen), according with manufacture instructions. Total protein extracts were resuspended in GNL buffer (10 mM HEPES, pH 7.5, 0.15 M NaCl, 0.1 mM CaCl_2) and 200 μg were loaded on agarose-bound GNL for enrichment (Vector Laboratories). After washing the column 10 times with GNL buffer, the glycoproteins were eluted with 3% acetic acid (100 μL for 3 times) and dried in speedvac. Afterwards, samples were resuspended in 50 mM ammonium bicarbonate and incubated at 80 °C for 10 min. Glycoproteins were subsequently reduced with 5 mM DTT (Sigma-Aldrich) in 50 mM ammonium bicarbonate at 60 °C for 30 min, followed by alkylation with 10 mM iodoacetamide (Sigma-Aldrich) in 50 mM ammonium bicarbonate for 30 min in the dark. Proteins were then digested with trypsin (Promega) overnight at 37 °C in a humidified chamber. The digestion was quenched by the addition of trifluoroacetic acid (TFA), and the samples were dried using a speed vacuum concentrator. Finally, the dried samples were resuspended in 2% acetonitrile and 0.2% formic acid before analysis by mass spectrometry. The mass spectrometry analysis was performed by nanoLC-MS/MS using a Vanquish neoUHPLC nano-LC coupled to a QExactive Plus mass spectrometer (Thermo Fisher Scientific). Glycopeptides were separated in the analytical column (EASY-Spray C18 PepMap, 100 Å, 150 mm $\times$ 75 μm ID and 3 μm particle size) at a flow rate of 0.25 $\mu\text{L}/\text{min}$, using a linear gradient of 12-46% eluent B over 50 min. Column wash and re-equilibration were warranted before the following injection. Column temperature was set at 35 °C. The mass spectrometer was operated in the positive ion mode, with an m/z range from 300 to 2000, a spray voltage of 1.9 kV, and a transfer capillary temperature of 275 °C. Q-Exactive Plus settings were full scan resolution 140k, automatic gain control (AGC) of $3\text{e}6$, maximum injection time of 200 ms. The top 15 peaks were selected for HCD fragmentation, using the following settings: fragment scan resolution 17,500, fragment scan fixed first mass at 110 m/z , AGC target of $1\text{e}5$, maximum injection time 100 ms, and isolation window 4.0 m/z . Data-dependent parameters

were as follows: minimum AGC target 7e3, exclusion of charge unassigned, 1, and > 8, peptide match preferred, exclude isotopes on, and dynamic exclusion of 30 s. Two MS runs were performed differing on nce applied: nce of 20% and stepped nce of 35 with 2 steps. Although technical replicates were not feasible due to limited FFPE material, instrument performance was consistently monitored using BSA tryptic digests throughout the LC-MS/MS runs. Mass spectrometry data was processed using the SequestHT search engine and the Percolator algorithm (Proteome Discoverer 3.0, Thermo Fisher Scientific) to validate protein identifications. Data were searched against the human proteome from the SwissProt database (accessed on November 16th, 2021). Trypsin was selected as the digestion enzyme, considering up to 3 missed cleavage sites, a precursor ion mass tolerance of 10 ppm, and a product ion tolerance of 0.02 Da. Fixed and variable modifications included carbamidomethylcysteine (+57.021 Da) and oxidation of methionine (+15.995 Da), respectively. The following *N*-glycans were also considered as variable modifications on asparagine (Asn-X-Ser/Thr; “X” does not correspond to Pro), building on glycome analysis: H₂N₂F₁ (+876.322 Da); H₂N₂ (+892.317 Da); H₃N₂F₁ (+1038.375 Da); H₅N₂ (+1216.423 Da); H₆N₂ (+1378.476 Da).

Glycoprotein Annotation and Data Curation

Identified proteins with high FDR confidence in the Proteome Discoverer analysis were comprehensively curated to identify relevant glycoproteins in GC progression and aggressiveness. Firstly, the generated glycoproteomic dataset was interrogated in terms of cellular location using Panther software (GO terms GO:0005886, GO:0005737, GO:0005634 and GO:0005840) (<https://www.pantherdb.org>) [50]. Subsequently, unique glycoproteomics signatures in the different analysis groups (early-stage versus advanced-stage tumours) were identified using a Venn Diagram analysis (<https://bioinformatics.psb.ugent.be/webtools/Venn/>). Furthermore, glycoproteins identified across groups were analyzed in terms of differential expression levels using Volcano Plots. An absolute Log2 fold change > 1 and

an adjusted p -value < 0.05 ($-\text{Log}_{10}$ p -value > 1.3) were considered in the Volcano Plot analysis. Unique and overexpressed glycosignatures in each group were analyzed in terms of their biological and molecular functions using ClueGO plugin from Cytoscape (<http://www.cytoscape.org/>), considering only significant pathways (p -value < 0.05) [51, 52]. Putative *N*-glycosylation sites on the identified carriers of paucimannosidic *N*-glycans were evaluated using NetNGlyc version 1.0 (<https://services.healthtech.dtu.dk/services/NetNGlyc-1.0>) [53].

Glycogenes Transcripts Analysis in Cancer Tissues

Total RNA from 11 FFPE GC tissues characterized by *N*-glycomics was isolated using High Pure FFPE RNA Isolation Kit (Roche) and converted into cDNA with the High Capacity cDNA Reverse Transcription Kit (Applied Biosystems). *HEXA*, *MAN2A1* and *MGAT2* gene expression was assessed by quantitative polymerase chain reaction (qPCR) and mRNA levels were normalized to the expression of *GAPDH* (glyceraldehyde-3-phosphate dehydrogenase). The relative mRNA levels were calculated using the formula $2^{-\Delta\Delta C_t}$ as described by Livak et al. [54]. All reactions were run in duplicates.

Transcripts and Glycoproteins Expressions *in silico*

mRNA expression levels of main glycosidases and glycosyltransferases (*HEXA*, *HEXB*, *MAN2A1*, *MAN2A2*, *MAN2B1*, *MGAT1*, and *MGAT2*) involved in paucimannose biosynthesis as well as *MMP9* were examined within a dataset comprising 412 gastric cancer cases. The analysis was conducted by re-examining data from the Genomic Data Commons (GDC) repositories (TCGA-STAD dataset) [55]. Detailed clinicopathological data on these data is presented in **Table 5**. Main outcomes included associations with stage, grade, metastasis and prognosis. In addition, we also compared the expression levels of these genes across healthy gastric mucosa, gastric cancer tissue, and histologically normal mucosa adjacent to tumors based on data sourced from The International Cancer Genome Project's Pan-Cancer

Analysis of Whole Genomes (PCAWG) available at the EMBL-EBI repository (accession E-MTAB-5200) [56]. In addition, glycoproteins linked to advanced stage disease and identified by MS/MS-based GNL-enrichment were assed in 31 healthy human tissues based on proteomics data from the EMBL-EBI repository (accession PXD010154) [57]. MMP9 expression levels in healthy tissues was also assessed through the generated antibody-based data from the Human Protein Atlas database (proteatlas.org) [58].

Table 5. Clinicopathological characteristics of the GC patients in the TCGA-STAD dataset used in this study (n = 412).

	<i>n</i> (%)
Male	267 (65)
Female	145 (35)
Stage	
I	58 (14)
II	122 (30)
III	169 (41)
IV	39 (9)
Missing information	24 (6)
Primary tumor (T)	
T1	22 (5)
T2	88 (21)
T3	181 (44)
T4	113 (28)
Missing information	8 (2)
Regional lymph nodes (N)	
N0	124 (30)
N1	109 (26)
N2	78 (19)
N3	82 (20)
Missing information	19 (5)
Distant metastasis (M)	
M0	365 (89)
M1	26 (6)
Missing information	21 (5)
Age (average, min-max)	66 years (30-90)

Immunohistochemistry for GNL, established GC biomarkers and MMP9

Both gastric tumours of different stages and histologically normal gastric mucosa were screened for GNL staining, established GC biomarkers and MMP9 expressions. Briefly, 3 mm tissue sections were deparaffinized, rehydrated and incubated for 20 min with boiling citrate buffer (Vector Laboratories) or EDTA pH 9. Tissue sections were then exposed to 3-4 % hydrogen peroxide for 5 min (Leica). GNL-ligands were detected using biotinylated GNL (B-1245-2; Vector Laboratories), E-cadherin using mouse anti-human E-cadherin (NCL-L-E-Cad; Leica), p53 using mouse anti-human p53 (M7001, Dako), MSI using antibodies anti-MLH1 (550838; BD Biosciences), anti-MSH2 (556349; BD Biosciences), anti-MSH6 (610918; BD Biosciences), anti-PMS2 (NCL-L_PMS2; Leica), sTn using mouse anti-tag-72 (ab199002; Abcam), sialyl-Lewis A using mouse anti-human CA19.9 (ab116024; Abcam), and MMP9 using rabbit anti-MMP9 (ab76003; Abcam). The Vectastain ABC kit (Vector Laboratories) and the Novolink Max Polymer DS Kit (Leica) were used, according to the manufacturer instructions, to detect biotinylated GNL and primary antibodies, respectively. Positive and negative controls were run in parallel for these antigens to validate the specificity and reliability of the staining process. Controls were elected based on the annotated expression in healthy tissues from The Human Protein Atlas database (proteinalas.org) [58]. For GNL binding, negative controls also included PNGase F treated tissue sections (for *N*-deglycosylation using 15 U of PNGase F per slide). Enzymatic controls using α -neuraminidase from *Clostridium perfringens* (Sigma-Aldrich) were applied to verify the specificity and accuracy of the immunohistochemical results for the two sialoglycans, sLeA and sTn. Semi-quantitative analysis of GNL, MMP9, E-cadherin, sTn and sLeA was performed, evaluating the percentage of positively stained cells (extension) and the intensity of the chromogenic signal. The final score for each marker was calculated as the product of extension x intensity, providing a composite measure of expression. The MSI phenotype was defined by the loss of expression of any of the analyzed mismatch repair proteins. Conversely, intense nuclear accumulation of p53,

as detected by immunohistochemistry using the DO-7 antibody, was interpreted as indicative of underlying *TP53* gene mutations. Sections were evaluated blindly by two independent observers and subsequently confirmed by an experienced pathologist. Image data was acquired using a BA310 Trinocular microscope with an integrated MOTICAM X5 Plus and a Motic ImagePlus 3.0 software (Motic).

Immunofluorescence

A selection of FFPE tissue sections positive for MMP9 and/or GNL were screened for both antigens through double immunofluorescence to determine colocalization between both epitopes. Tumor and healthy gastric mucosa sections that were positive for only one of these markers or negative for both were screened in parallel as controls. Briefly, FFPE tissues were deparaffined, hydrated and exposed to antigen retrieval with EDTA 1 mM pH8. GNL-ligands and MMP9 were detected using biotinylated GNL (B-1245-2; Vector Laboratories) and anti-MMP9 (ab76003; Abcam), respectively. An anti-rabbit Alexa Fluor 594 (Thermo Fisher Scientific) was used to detect anti-MMP9 primary antibody, and a streptavidin-Alexa Fluor 488 was used as secondary fluorescent detector for the biotinylated GNL. Nuclear counterstain was reached using 4',6-Diamidino-2-phenylindole dihydrochloride (DAPI, Thermo Fisher Scientific). Fluorescence images were acquired on Biotek Cytation C10 Confocal Imaging Reader (Agilent) and generated imaging data was processed and analyzed using Fiji software package. Co-localization analysis was performed by generating a co-localization pixel map through the Colocalization Threshold Test in Fiji software, providing insights into the spatial relationship between the detected antigens.

MMP9 Immunoprecipitation

MMP9 protein was isolated from total proteins extracts excised from MMP9-GNL positive tumour tissues (300 µg) through immunoprecipitation using 3 µg of anti-MMP9 antibody (ab76003; Abcam) adsorbed to the surface of

Pierce TM Protein G agarose beads (Thermo Fisher Scientific), as previously described by us [8]. Briefly, after blockage of the Protein G agarose beads with 1 % of bovine serum albumin (BSA, Sigma-Aldrich), protein extracts were precleaned using the blocked agarose beads to reduce unspecific binding. Then, the cleared supernatant was incubated with 3 µg of anti-MMP9 antibody for 2 h at 4 °C, followed by overnight incubation with BSA-blocked agarose beads. After washing, immunoprecipitated MMP9 was eluted with 3 % acetic acid, dried under vacuum and digested with trypsin as described above. Generated peptides were analyzed by mass spectrometry under the same conditions of the glycoproteomics analysis.

GNL and MMP9 profiling in serum

GNL and MMP9 serum levels were assessed in a sample set of 89 individuals, comprising both healthy donors and cancer patients, using dot blotting. Demographic and clinicopathological characteristics are summarized in **Table 6**. Briefly, 50 µg of serum proteins, diluted in PBS, were applied onto a nitrocellulose membrane using the Hybrid-dot Manifold system (1050MM, Bethesda Research Laboratories). Membranes were then blocked with either 50% Carbo-free 1× solution for GNL detection or 3% non-fat milk for MMP9 detection. For GNL analysis, membranes were incubated with biotinylated GNL (1:40000, B-1245-2; Vector Laboratories) for 1 h at RT, followed by detection using the ABC Peroxidase kit (Vector Laboratories). For MMP9, membranes were incubated with primary antibody (1:1000; ab76003; Abcam) for 1 h at RT and detected with an HRP-conjugated anti-rabbit secondary antibody (Thermo Fisher Scientific). Antibody-reactive signals were visualized via chemiluminescence. Positive and negative controls - including BSA and PNGase F-treated samples (to remove *N*-glycans) - were included in parallel to validate specificity.

Table 6. Demographic and clinicopathological profiles of Healthy Donors and GC patients in the GNL and MMP9 serum reactivity analysis (n = 89).

Healthy donors (n = 40)		<i>n (%)</i>
Male		26 (65)
Female		14 (35)
Age (average, min-max)		39 years (21-61)
Cancer patients (n = 49)		<i>n (%)</i>
Male		20 (41)
Female		29 (59)
Stage		
I		11 (23)
II		8 (16)
III		11 (23)
IV		12 (24)
Missing information		7 (14)
Primary tumor (T)		
T1		7 (14)
T2		6 (12)
T3		14 (29)
T4		9 (18)
Missing information		13 (27)
Regional lymph nodes (N)		
N0		17 (35)
N1		3 (6)
N2		7 (14)
N3		9 (18)
Missing information		13 (27)
Distant metastasis (M)		
M0		33 (68)
M1		7 (14)
Missing information		9 (18)
Lauren's classification		
Intestinal type		24 (49)
Diffuse-type		10 (20)
Mixed		4 (8)
Missing information		11 (23)
Age (average, min-max)		63 years (36-83)

Statistical analysis

Parametric and non-parametric statistical tests, including t-tests and the Kruskal-Wallis' test, were employed to compare mRNA and protein expression levels across two or more independent groups. Outliers were identified and removed using the ROUT method ($Q = 1\%$) prior to statistical testing, and data normality was assessed using the Shapiro-Wilk test. The mRNA and protein expression levels were analyzed in relation to clinically relevant parameters, such as clinical stage and TNM classification. Chi-square test was used to evaluate the statistical relationships between MMP9-GNL expression and clinical stage, T stage and metastasis. Correlation analyses were performed using Pearson's correlation method for the glycosyltransferases, glycosidases and *MMP9* mRNA levels, while Spearman's correlation was used to assess the correlation between *HEXA*, *MAN2A1* and *MGAT2* mRNA and paucimannose levels, as between GNL and MMP9 serum levels. The prognosis value of analysed variables was assessed through univariate, and subsequent multivariate Cox regression (co-variables: clinical stage, tumour stage, lymph node involvement, metastasis status). Kaplan-Meier analysis, combined with the log-rank test, was used to compare overall survival curves, with overall survival defined as the time from surgery to the date of patient death. For TCGA data, optimal cut-off value for each gene expression was determined using the *surv_cutpoint* function of the R-package *survminer*, for overall survival outcomes. The clinical value of serum GNL and MMP9 levels was evaluated using Receiver Operating Characteristic (ROC) curve analysis, with the optimal cutoff values determined by the Youden Index. A significance threshold of 95% for the null hypothesis was applied. Statistical analysis was conducted using GraphPad Prism 10 (Dotmatics), IBM Statistical Package for Social Sciences (SPSS; IBM) and R (version 4.4.2) for MacOs.

Data Accessibility

The mass spectrometry data have been deposited to the ProteomeXchange Consortium via the PRIDE partner repository with the dataset identifier

PXD060153 [59]. Glycomics data have been deposited at GlycoPost (accession number GPST000546) [60].

Results

This study addresses the intestinal-type tumors, which account for approximately 42% of all gastric cancer cases in European countries [61]. Tumors were classified into two groups based on prognosis: early-stage, confined to the mucosa or submucosa (T1a, T1b), which are more amenable to curative treatment; and advanced-stage ($\geq$ T2), characterized by deeper invasion and often accompanied by lymph node or distant metastases, leading to poorer outcomes (**Tables 1 and 2; Figure S1**). The primary objective was to uncover *N*-glycomic alterations associated with disease aggressiveness and to guide subsequent glycoproteome analysis, aiming to identify molecular signatures that could enhance patient stratification and enable precise tumor targeting.

Advanced stage GC is enriched for trimmed *N*-glycans

To address the poorly understood GC *N*-glycome, we extracted *N*-glycans from tumor tissue sections via on-site *N*-deglycosylation using PNGase F. Briefly, *N*-glycans were directly released from minimal amounts of tumor tissue immobilized on glass slides ($\geq 10 \mu\text{m}$ thick), permethylated, and analyzed by nanoLC-MS/MS. A total of 126 distinct glycan structures were identified, with 107 *N*-glycans detected in early-stage gastric cancer and 90 in the advanced-stage group (**Table S1**). The identified *N*-glycans were categorized into four main types: oligomannose glycans, characterized by the presence of 5 to 9 mannose residues; complex glycans, which feature a core of three mannose residues further extended by other sugars; hybrid glycans, combining features of both oligomannose and complex glycans; and paucimannose glycans, which are truncated forms containing up to four

mannose residues, often resulting from the enzymatic trimming of recently formed hybrid *N*-glycans (**Figure S2**). Complex *N*-glycans were found as the predominant glycosidic chains in GC (50-80% of total glycans), irrespective of disease stage (**Figures 1A-B; Table S1**). Interestingly, the levels of sialylation, capping glycans often found in these structures and reported to change with cancer progression, remained similar across groups. Other major classes of *N*-glycans included oligomannosidic (15–35%; **Figure 1B; Table S1**) and paucimannose structures (5–20%; **Figure 1B, Table S1**), the latter being a relatively underexplored class in humans, thought to arise from the trimming of complex and hybrid *N*-glycans. Hybrid *N*-glycans were also detected in low amounts, comprising less than 2% of the total *N*-glycome (**Figure 1B; Table S1**). Notably, with disease progression we found a significant increase in paucimannose and a decrease in hybrid *N*-glycans (**Figures 1A-B, Table S1**). Also, the main paucimannose structures increased in cancer were $H_2N_2F_1$ and H_3N_2 , as highlighted by typical MS/MS spectra (**Figure 1C**).

To further validate and quantify the expression of paucimannose structures, we performed immunohistochemical screening of the tumors using GNL. GNL is specific for $\alpha 1$ -6 and $\alpha 1$ -3 mannose terminal linkages, which are characteristic of the predominant paucimannose structures identified through mass spectrometry ($H_2N_2F_1$ and H_3N_2 ; **Table S1**) [62]. Notably, although it preferentially binds to paucimannose structures, it also exhibits weaker affinity for hybrid *N*-glycans, which represent a low-abundance population and are reduced in advanced GC (**Figures 1A-B**). Additionally, it binds to oligomannose structures, which remain unchanged during disease progression (**Figures 1A-B**), supporting to be a good approach to assess the expression of trimmed glycans. Accordingly, both healthy gastric mucosa obtained from healthy donors and gastric tumors displayed reactivity to GNL lectin, with staining observed predominantly in the cytoplasm and, to a lesser extent, at the plasma membrane (**Figure 1D**). In gastric tissues, GNL expression was predominantly localized in basal glandular cells and intraepithelial immune cells, being more prevalent in invasive tumour fronts.

Beyond the stomach, GNL staining was further observed in cells within the exocrine pancreas, germinal cells of the testis, basal and keratin layers of the skin, and intraepithelial immune cells in the colon (**Figure S3**). These findings highlight the potential diverse distribution of paucimannose structures across relevant healthy tissues, including epithelial and immune cell populations in both gastric and extra-gastric contexts. Despite these observations, we also found higher GNL reactivity in GC in relation to healthy organs (**Figure 1D**). Furthermore, there was a noticeable increase with the stage and grade of the disease as well as with the presence of lymph node and distant metastases (**Figures 1E-F**). Furthermore, higher GNL reactivity was significantly associated with decreased overall survival ($p = 0.029$; **Figure 1G**), reinforcing the close link between the overexpression of paucimannose and aggressive GC traits. Additionally, half of the metastasized lymph nodes exhibited positivity for GNL (**Figures S4A-C**). Patients with GNL-positive lymph nodes showed decreased overall survival (**Figure S4D**), consistent with observations in primary tumors that link these glycan alterations to increased GC aggressiveness. Notably, based on multivariate analysis, GNL was not observed as an independent predictor of worst prognosis (data not shown). Nevertheless, collectively, our findings link GNL staining to more aggressive cases. We further expanded our patient cohort to include diffuse and mixed-type tumours, which are less prevalent and generally associated with more aggressive clinical behavior in gastric cancer (**Figure S5A-D**). GNL reactivity was significantly higher in intestinal-type tumours compared to diffuse-type, while no significant differences were observed for mixed-type tumours (**Figure S5B**). Notably, although mixed-type tumours were underrepresented in our cohort due to their lower incidence, we also observed elevated GNL reactivity in this subgroup. Additionally, GNL reactivity showed a trend toward association with more aggressive tumour phenotypes and poorer prognosis ($p = 0.051$; **Figure S5D**). Finally, building on reports linking changes in glycosylation to aging [63, 64], we further assessed the effect of age on glycan expression. However, no significant correlation was observed between age and GNL

reactivity in our cohort, suggesting that the observed glycomic alterations are more closely related to disease progression rather than age-related physiological changes.

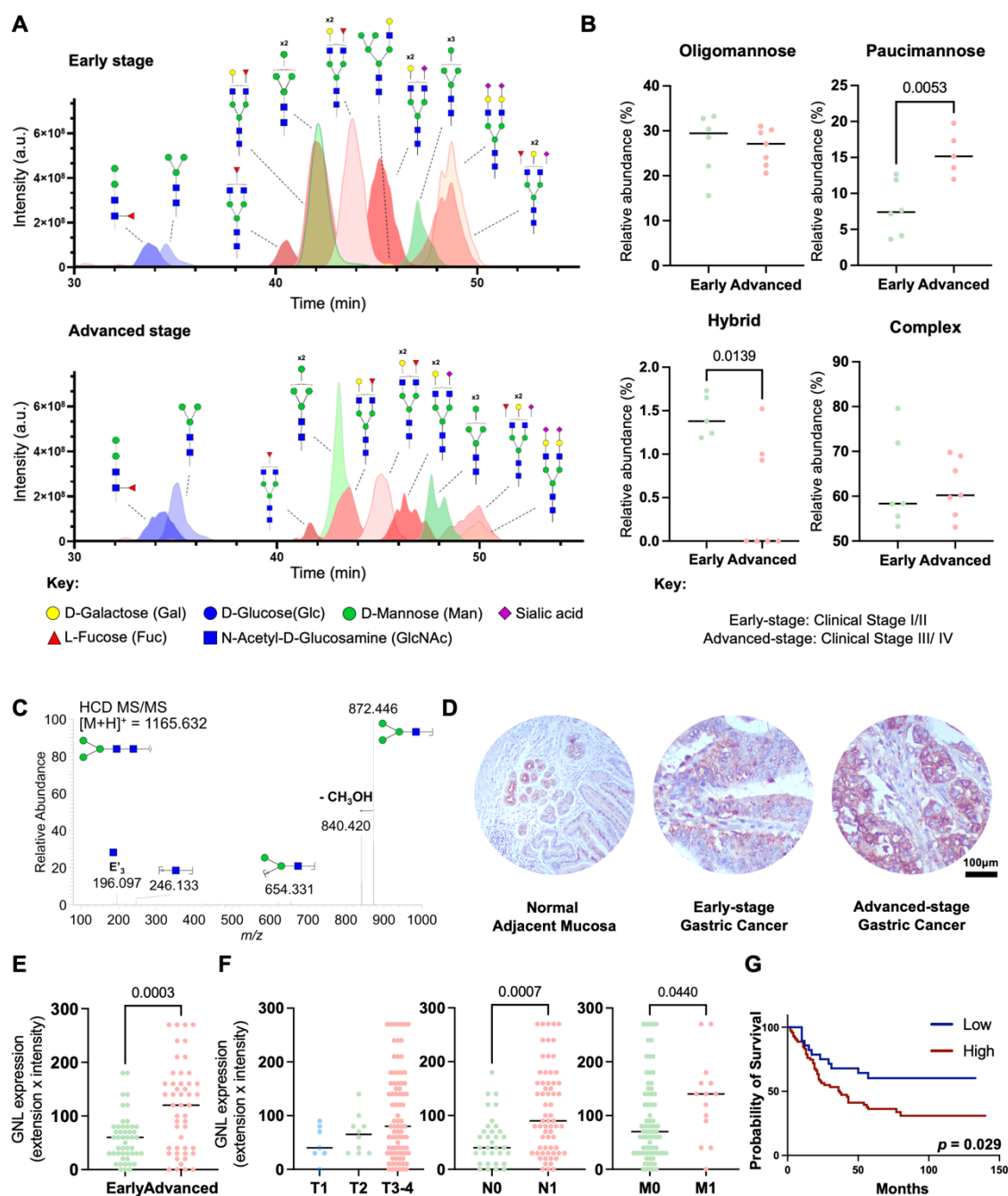


Figure 1. Advanced-stage GC tumours exhibit increased levels of paucimannosidic *N*-glycans associated with worst prognosis. A. Advanced stage GC (III/IV) exhibit distinctive glycomics compared to early stages (I/II), characterized by higher levels of

trimmed *N*-glycans. The Extracted Ion Chromatograms (EICs) show most abundant *N*-glycans identified in glycomics analysis. Advanced-stage GC tumors exhibit higher levels of specific paucimannoses (blue) and lower levels of complex *N*-glycans (red) compared to early-stage tumors. In contrast, the relative expression pattern of oligomannoses (green) remains unchanged. **B. Advanced stage tumours expressed higher levels of paucimannoses.** The relative abundance of different classes of *N*-glycans across GC stages ($n = 13$; stage I/II: 6, stage III/IV: 7) was assessed, revealing lower levels of hybrid *N*-glycans ($p = 0.0139$) and higher levels of paucimannoses ($p = 0.0053$) at advanced stages compared to early stages of the disease. No additional significant associations were observed for the remaining classes of *N*-glycans. Unpaired t-test or Mann-Whitney test were applied, after determination of data normality (Shapiro-Wilk) and outliers' removal. Statistical significance was considered when $p < 0.05$. **C. MS/MS spectrum for the permethylated reduced paucimannose H_3N_2 at m/z 1165.6.** The MS/MS shows major ions corresponding to the B_3 fragmentation and the subsequent loss of CH_3OH , at m/z 872.4 and 840.4, respectively. Two internal fragments were also observed at m/z 246.1 and 654.3. Additionally, the fragment glycan ion at m/z 196.1 results from elimination of the substituents at positions 3 and 4 (E'_3) in the GlcNAc B-ion. **D-E. GNL staining, used as a surrogate for paucimannose expression, is increased in GC compared to histologically normal mucosa and increases with disease severity.** Immunohistochemical evaluation using GNL lectin revealed the presence of paucimannosidic *N*-glycans in healthy gastric mucosa, particularly in basal glands and intraepithelial immune cells. Advanced-stage tumours exhibited significantly increased expression of these glycans ($p = 0.0003$) predominantly in the cytoplasm of tumour cells but also at the cell membrane. Unpaired t-test was performed, after outliers' removal (ROUT method) and data normality determination (Shapiro-Wilk test). Statistical significance was considered when $p < 0.05$. **F. GNL staining is higher in the primary intestinal-type tumors of metastatic patients.** GNL staining is significantly increased in cases presenting lymph node metastasis ($n = 100$; $p = 0.0007$) and/or distant metastasis ($n = 91$; $p = 0.0421$). Kruskal-Wallis's test was used to compare the expression levels in the T stage and Mann-Whitney test was implemented to compare GNL expression in metastatic tumors. Outliers were removed from the analysis and data normality was evaluated using Shapiro-Wilk test. Statistical significance was defined as $p < 0.05$. **G. Patients overexpressing GNL-ligands present the worst prognosis ($p = 0.0410$).** Log-rank (Mantel Cox) was used to compare survival distribution between groups. A p -value of less than 0.05 was considered statistically significant.

Prognostic value of GNL vs classical biomarkers

Focusing on intestinal tumours, we assessed the prognostic value of GNL and further compared it with other clinically relevant gastric cancer biomarkers, including E-cadherin, p53, MSI, and the cancer-associated glycans sTn and sLeA. Primarily, we observed significantly decreased E-cadherin expression in advanced-stage tumours, accompanied by a trend toward an association with reduced overall survival (**Figure S6A**). These findings are consistent with previous reports linking E-cadherin loss to tumour progression, poor prognosis, and its role in epithelial-to-mesenchymal transition, a key mechanism driving cancer invasion and metastasis [65-67]. On the other hand, accumulation of p53, most likely resulting from underlying mutations, showed no significant association with tumour stage or patient survival (**Figure S6B**) [68]. These findings are consistent with report indicating that p53 immunoreactivity alone is not a reliable prognostic marker in GC [69]. MSI was determined based on the assessment of four DNA repair proteins (MLH1, MSH2, MSH6 and PMS2), following established guidelines for the classification of MSI status. We found higher MSI positivity among early-stage intestinal-type gastric tumours, with significant associations observed with no lymph node involvement, no distant metastasis, and increased overall survival (**Figure S6C**). These findings reinforce previous observations in intestinal-type gastric cancer linking MSS to disease aggressiveness [70]. sLeA was associated with distant metastasis, reflecting its known biological role in facilitating cancer cell intravasation into the bloodstream and extravasation at distant sites [71]. It was also significantly associated with decreased overall survival (**Figure S6D**). In contrast, the glycan epitope sTn showed no clear association with disease stage or metastatic spread, but was linked to reduced survival, consistent with previous reports (**Figure S6E**) [72, 73]. Collectively, these glycan epitopes reflect profound alterations in the tumour glycocalyx and underscore the potential of glycosylation-based biomarkers for patient stratification.

Using receiver operating characteristic (ROC) curve analysis, we compared the prognostic performance of classical biomarkers with GNL, which demonstrated superior predictive capacity (AUC = 0.7086, $p = 0.0004$; sensitivity: 62.5%; specificity: 83.3%; **Figure 2**). Among all tested biomarkers, GNL yielded the highest AUC, as well as the best balance between sensitivity and specificity (**Figure 2**). Additional analyses combining GNL with other biomarkers did not result in a relevant improvement in predictive performance (data not shown). These results indicate that GNL possesses clinically relevant prognostic potential in intestinal-type gastric cancer, outperforming classical biomarkers in both statistical significance and overall discriminative ability. Its high specificity is particularly promising for stratifying patients at risk of poor outcomes, although the moderate sensitivity suggests it may benefit from combination with complementary markers in future models. Nonetheless, GNL stands out as a strong candidate for further validation as a prognostic biomarker.

In an effort to explore the potential of GNL as a non-invasive circulating biomarker, we also evaluated its detection in serum samples from a subset of the patient cohort (**Table 6**). However, GNL levels in serum did not distinguish cancer patients from individuals with non-malignant pathologies (**Figures S7A-C**). Furthermore, it did not show any correlation with age (data not shown). Moreover, it showed no significant association with histological subtypes (intestinal, diffuse, mixed), disease stage, metastatic status, or overall survival (**Figures S7D-F**). These findings suggest that while GNL exhibits strong prognostic value in tissue, its utility in serum may be limited, potentially due to low circulating abundance, interference from abundant serum glycoproteins, or altered glycan presentation. Further methodological optimization and assay refinement will be necessary to evaluate its potential for liquid biopsy applications.

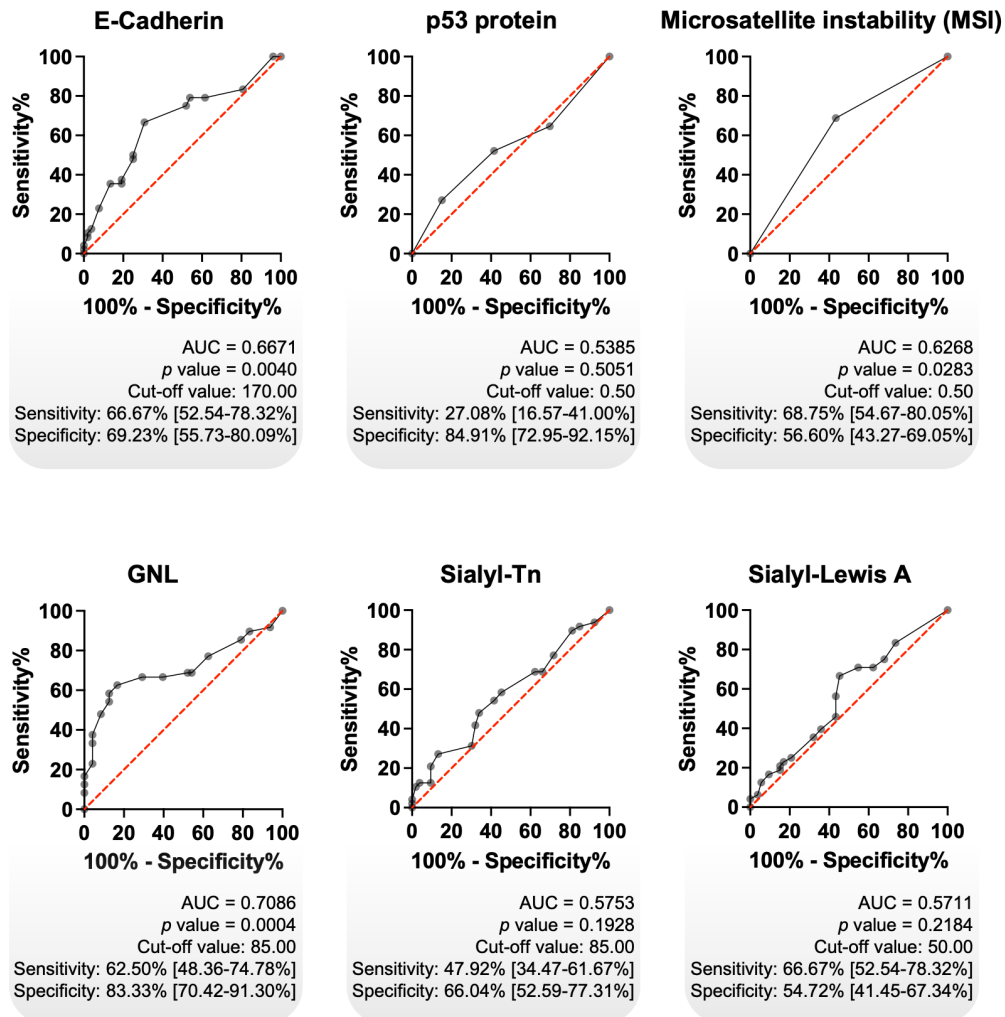


Figure 2. GNL exhibited the highest diagnostic accuracy among classical GC biomarkers. Receiver Operating Characteristic (ROC) curve analysis was performed on intestinal-type GC tumours, using immunohistochemistry data, to evaluate the potential of each biomarker in distinguish early-stage from advanced-stage disease ($n = 101$). GNL showed the highest diagnostic performance (AUC = 0.7086; $p = 0.0004$), with notably high specificity (83.33%), followed by E-Cadherin (AUC = 0.6671; $p = 0.0040$) and MSI phenotype (AUC = 0.6268; $p = 0.0283$). In contrast, p53, Sialyl-Tn (sTn), and Sialyl-Lewis A (sLeA) did not demonstrate statistically significant diagnostic value. The diagonal red line indicates the reference line (random classifier), while the black curves represent the performance of each biomarker. Cut-off values were determined using Youden's index. A p value of less than 0.05 was considered statistically significant. AUC stands for Area Under the Curve.

Glycogenes linked to paucimannose biosynthesis

We further explored the expression of glycogenes involved in the trimming of hybrid *N*-glycans leading to paucimannose structures, exploiting the Expression Atlas and The Cancer Genome Atlas Program (TCGA) databases comprehending over 400 GC cases of different stages and grades of the disease (**Table 5**). These include genes encoding for multiple glycosidases (*HEXA*, *HEXB*, *MAN2A1*, *MAN2A2*, *MAN2B1*) and glycosyltransferases responsible for mannose core extensions, such as *MGAT1*, linked to initiating the first branch in complex, as well as hybrid, *N*-glycans, and *MGAT2*, which facilitates the formation of bi-antennary structures (**Figure 3A**). All glycosidases and glycosyltransferases, except *MGAT1*, were significantly elevated in GC compared to adjacent normal gastric mucosa (**Figure 3B**). Moreover, *HEXA*, *HEXB*, *MAN2A1*, and *MAN2B1* were overexpressed in cancer relative to healthy stomachs from individuals without gastric pathologies (**Figure 3B**). Additionally, all glycosidases showed strong positive correlations in gastric tumors (**Figure 3C**), indicating a permissive microenvironment for the accumulation of trimmed glycans in cancer. **Figures 3D-F** highlight clinically significant features, including elevated *MAN2A1* and *MAN2A2* expressions in advanced clinical stages (III/IV) and T stages (T2-T4), and *HEXB* specifically in T4 tumors (**Figures 3D-F**). Additionally, *MAN2A1* overexpression was significantly associated with reduced survival ($p = 0.020$; **Figure 3G**), while *HEXA*, despite not increasing with disease progression, showed a trend toward reduced survival ($p = 0.097$; **Figures S8A-B**). In addition, we also observed a statistically significant decrease in *MGAT2* expression in T3 tumors (**Figure 3H**). These findings highlight a link between paucimannose-related glycogenes and cancer aggressiveness, consistent with the glycome analysis (**Figure 1**). Notably, *MGAT1* mRNA levels also significantly increased in advanced T stages ($\geq T2$), while *MAGT2* showed upregulation in T2 tumors (**Figures 3H-I**). This aligns with the predominance of complex glycans in GC and suggests their co-expression with paucimannoses (**Figures 1A-B**). Furthermore, this

suggests that the accumulation of trimmed *N*-glycans in GC tissues may be primarily driven by glycosidase overexpression rather than a downregulation of the glycosyltransferase responsible for mannose branching towards complex glycans. Reinforcing this hypothesis, our data highlight a significant positive correlation between paucimannose levels (**Figures 1A-B**) and the expressions of *HEXA* and *MAN2A1* in tumors ($R = 0.67-0.75$; **Figure 3J**).

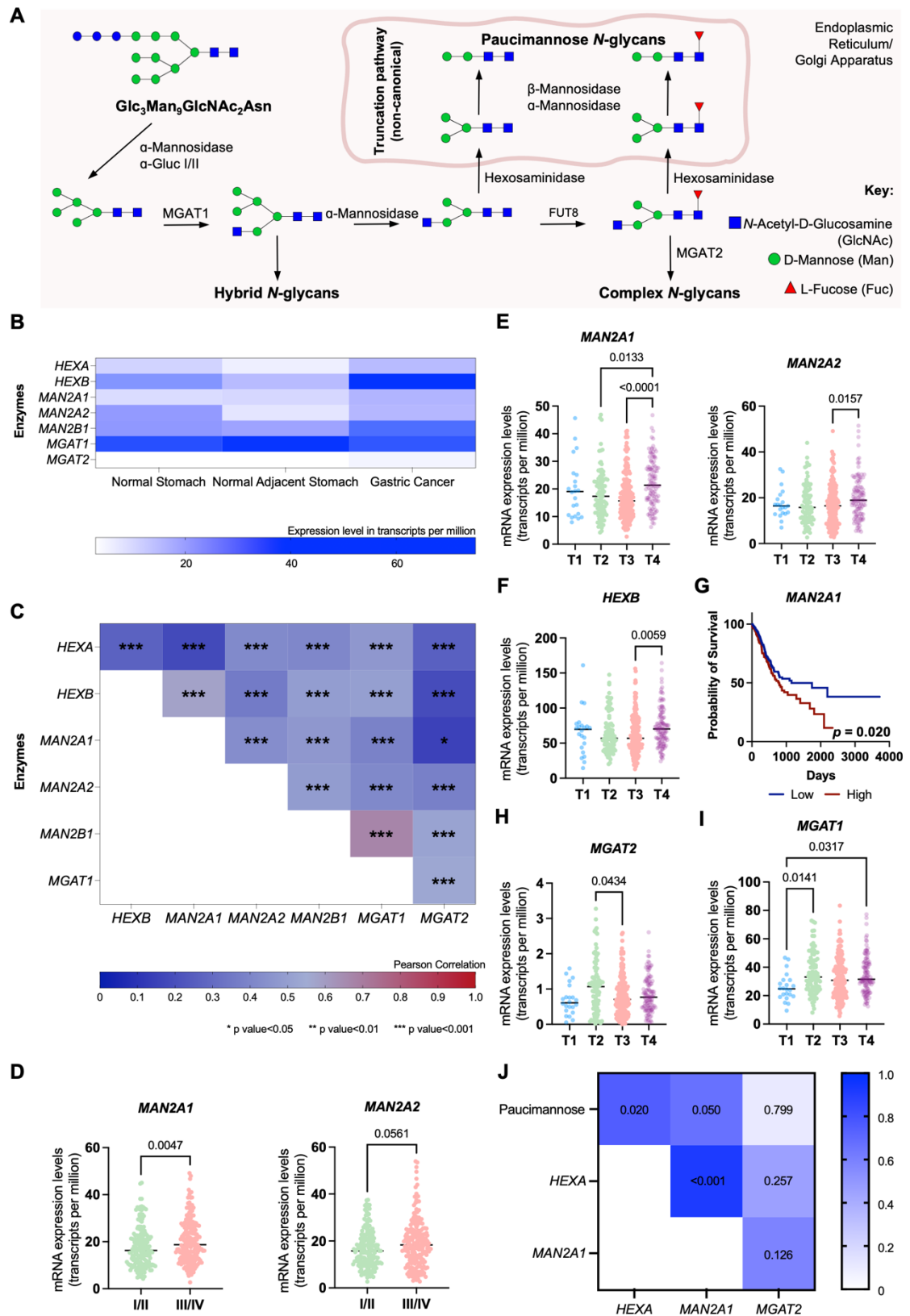


Figure 3. Aggressive forms of GC significantly upregulate key glycosidases linked to paucimannose expression. A. *N*-glycan biosynthesis pathway highlighting

glycosidases and glycosyltransferases regulating glycosidic chain trimming. α -mannosidases (MAN2A1, MAN2A2), β -mannosidases (MAN2B1) and hexosaminidases (HEXA and HEXB) are the main responsible for trimming *N*-glycans and originating paucimannose. On the other hand, MGAT1 and MGAT2 are amongst the main responsible for the elongation of *N*-glycans. **B. Paucimannose-related glycosidases are significantly overexpressed in GC tissues compared to adjacent healthy mucosa and mucosa from non-GC patients. In contrast, *MGAT1* is predominantly expressed in healthy tissues, and *MGAT2* is minimally expressed. This indicates a microenvironment favoring trimmed *N*-glycan formation in GC tissues.** **C. Glycogenes associated with *N*-glycan trimming display varying positive correlations ($0.150 < R < 0.670$, $p < 0.05$) in TCGA GC data ($n = 412$). Pearson's correlation was applied to show the level of correlation between the expression of the different glycogenes.** **D. Mannosidases (*MAN2A1*, *MAN2A2*) show significant upregulation in advanced-stage (III/IV) compared to early-stage (I/II) GC.** **E-F. Advanced T-stage tumors (T4) exhibit upregulation of *MAN2A1*, *MAN2A2* (E) and *HEXB* (F) compared to earlier T stages. *MAN2A1* is significantly upregulated in T4 compared to T2 ($p = 0.0133$) and T3 ($p < 0.0001$), while *MAN2A2* is elevated in T4 relative to T3 ($p = 0.0157$). *HEXB* is also significantly upregulated in T4 tumors ($p = 0.0059$).** **G. Patients with *MAN2A1* upregulation face worse prognosis ($p = 0.020$), as shown by overall survival analysis (Log-rank test).** **H. *MGAT2* expression is significantly reduced in T3 ($p = 0.0434$) and shows a downward trend in T4 compared to T2 tumors.** **I. *MGAT1* is significantly upregulated in aggressive tumors, with higher expression in aggressive tumours (T2: $p = 0.0141$; T4: $p = 0.0317$) compared to T1.** **J. Gastric tumours from IPO-Porto's patient set revealed a significant correlation between glycosidases and paucimannose relative expression according to glycomics.** A positive correlation was observed between the mRNA levels of *HEXA* and *MAN2A1* and the relative abundance of paucimannosidic *N*-glycans in GC tumors (*HEXA*: $R = 0.750$, $p = 0.020$; *MAN2A1*: $R = 0.667$, $p = 0.050$). Additionally, the expression levels of *HEXA* and *MAN2A1* were strongly correlated ($R = 0.917$, $p < 0.001$) as observed for TCGA data (A). Correlations were assessed using Spearman's correlation test. Otherwise stated, data were assessed for normality (Shapiro-Wilk test), and outliers were removed using the ROUT method. Tests used include Mann-Whitney for analysis in panel D and Kruskal-Wallis for panels E-I. For all analyses, statistical significance was set at $p < 0.05$.

Proteomics and Glycoproteomics identifies signatures of GC aggressiveness

To establish a rationale for selectively targeting more aggressive gastric tumors, we characterized both the whole proteome and *N*-glycoproteome of tumor regions excised from FFPE tissues. We employed a GNL-enrichment strategy to selectively isolate *N*-glycoproteins potentially carrying trimmed mannoses, utilizing conventional bottom-up glycoproteomics techniques supported by nanoLC-MS/MS analysis with HCD fragmentation (**Figure 4A**). Our analysis identified 1697 proteins from minute amounts of cancer cells, primarily localized to the cytoplasm (57%), nucleus (23%), plasma membrane (15%), and ribosome (5%) (**Figure S9A**). We identified significant differences between the proteomes of early- and advanced-stage tumors, with proteins like DCN and SGTA underexpressed and IFI30 and TACSTD2 overexpressed as the disease progressed (**Figure S9B**). Notably, 18 glycoproteins were exclusive to early-stage tumors, while 8 were found only in advanced stages (**Figure S9C**). Early-stage tumors displayed enrichment in proteins associated with stress adaptation (e.g., HMGB1, HSP90AA2P, MT1M, GSTA1), immune system interactions (HLA-DRB3, C4B, HMGB1), and invasion/migration (SPRR2D, CNFN, RAB13, KRT6C). These findings also suggested metabolic shifts (RAB3C, RAB13, DYNLL1) and cytoskeletal remodeling (MYL1, TUBA3D, KRT6C), supporting enhanced motility and invasiveness. Stress-related proteins further hinted at mechanisms of resistance to drug-based therapy. GO term analysis reinforced these observations, highlighting enrichment for extracellular binding and processes linked to cell adhesion and cytoskeletal remodeling (**Figure S9D**). Interestingly, there was also an enrichment for substantia nigra development, a process critical for midbrain functionality (**Figure S9D**). This suggests tumors might adopt neuronal mimicry traits, acquiring plasticity, forming synapse-like structures, and expressing neuronal markers, potentially aiding in evasion of immune surveillance and enhancing adaptive invasiveness, as previously observed for other digestive tract

tumours. Collectively, these strategies point out an integrated survival strategy towards sustained growth and spread at early stages. At advanced stages, we identified elevated levels of proteins associated with key cancer hallmarks, including vesicular trafficking and cellular signaling (RAB3B, RAB5B), immune modulation (HLA-DRB1), stress response and protein folding (COA4, ST13P4), epigenetic regulation (ANP32CP), oxidative stress defense (MT2A), and genomic stability (H2BC1) (**Figure S9C**). These changes support processes critical for tumor progression, such as enhanced survival, immune evasion, chemoresistance, and metastasis. A detailed GO terms enrichment analysis highlighted significantly altered molecular functions, emphasizing disruptions in kinase activities, regulation of protein synthesis and degradation, and extracellular matrix interactions (**Figure S9E**). Moreover, advanced tumors demonstrated enrichment in proteins involved in RNA splicing and antigen processing and presentation, suggesting broad reprogramming of molecular pathways to sustain aggressive tumor behavior and immune escape (**Figure S9E**). Collectively, the proteomics analysis underscores the distinct molecular landscapes of early and advanced stages of gastric cancer. It also highlights the utility of FFPE samples as a valuable resource for GC proteome characterization, offering potential for biomarker discovery and therapeutic insights.

GNL enrichment led to the identification of 385 proteins, with 250 predicted to contain *N*-glycosites (**Table S2**), and 96% detected across both early and advanced stages of the disease. However, the unequivocal confirmation of *N*-glycosites carrying paucimannose structures was achieved for only thirteen glycoproteins, likely due to the low abundance of available material. Among the identified proteins, 6 were more abundant in early stages, while 18 showed increased levels in advanced stages (**Figure 4B**). Interestingly, 10 proteins were exclusively detected in early stages, compared to 12 unique to advanced stages (**Figure 4C**). Notable findings of well-known GC-associated glycoproteins carrying trimmed glycosylation include plasma membrane glycoproteins such as CEACAM6 (**Figure 4D**) and secreted glycoproteins like MMP9. Despite these findings, 91% of the proteins were

of intracellular origin, consistent with prior studies linking paucimannosidic *N*-glycans predominantly to intracellular proteins (**Figure 4E**) [17, 74]. Examples include advanced-stage-associated proteins such as RPS11, a ribosomal protein confirmed to bear paucimannose residues, also showing a typical MS/MS consistent with the presence of these glycans (**Figure 4F**). In addition, several high-confidence non-glycosylated peptides corresponding to these proteins were identified, further strengthening and validating their assignment in the glycoproteomic analysis (**Figure S10**). Furthermore, advanced-stage-associated proteins carrying paucimannosidic *N*-glycans are linked with cytoplasmic translation and rRNA binding (**Figure 4G**), reinforcing the presence of paucimannose residues in proteins mainly located in the cytoplasm.

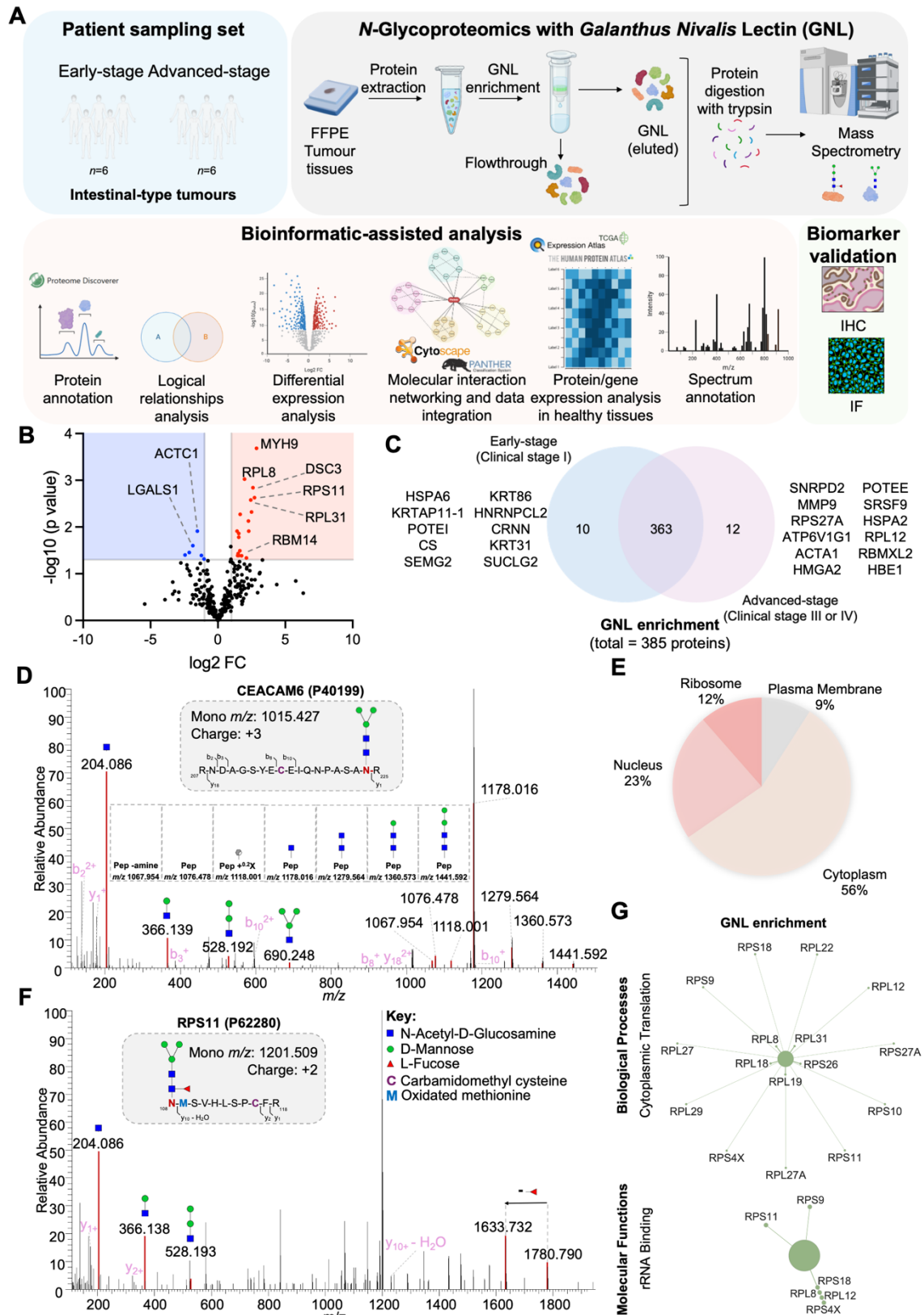


Figure 4. Paucimannosidic glycoproteome associated with aggressiveness. A. Roadmap for identifying putative carriers of paucimannosidic *N*-glycans. Proteins were extracted from FFPE GC intestinal-type tumor sections (6 early-stage vs. 6 late-stage tumors)

to identify glycoproteome signatures linked to cancer aggressiveness. Glycoproteins potentially carrying paucimannose structures were enriched using GNL-affinity chromatography and identified through conventional bottom-up proteomics using nanoLC-HCD-MS/MS. The presence of *N*-glycans in the identified glycoproteins was confirmed via manual spectral verification and annotation. Relevant paucimannosidic *N*-glycans associated with cancer aggressiveness were validated through various immunoassays. Cartoon elements were created using Biorender.com. **B. GNL-enrichment identified 386 glycoproteins in GC, 18 elevated in advanced stages (red) and 6 proteins in early stages (blue).** Notable proteins in advanced stages include MYH9, RPL8, DSC3, RPS11, RPL31, and RBM14, while ACTC1 and LGALS1 are overexpressed in early stages. **C. GC exhibited unique stage-related GNL-glycoproteomes.** Venn diagram analysis highlights 12 proteins exclusive to advanced stages (e.g., MMP9, RPL12, ACTA1) and 10 proteins unique to early stages (e.g., KRT31, CS, POTE1). **D. CEACAM6, a typical plasma membrane protein, is a carrier of paucimannosidic *N*-glycans.** MS/MS spectrum for the *N*-glycopeptide ($_{207}\text{RNDAGSYECEIQNPASANR}_{225} + \text{H}_3\text{N}_2$) highlights the presence of glycan oxonium ions and neutral glycan losses. **E. GNL-enriched glycoproteins were predominantly localized intracellularly.** Glycoproteome data integration based on Gene Ontology (GO) terms for cellular localization, analyzed using the PANTHER bioinformatics tool, reveals an overrepresentation of cytoplasmic proteins (56%). This is followed by lower representations of nuclear (23%), ribosomal (12%), and plasma membrane (9%) proteins. **F. Ribosomal protein RPS11 is a carrier of paucimannosidic *N*-glycans.** MS/MS spectrum support the existence of $\text{H}_3\text{N}_2\text{F}_1$ *N*-glycan on the peptide $_{108}\text{NMSVHLSPCFR}_{118}$. The spectrum presents the glycan oxonium ions at m/z 244.086, 366.139 and 528.190, and a loss of fucose moiety, supporting the existence of this paucimannosidic *N*-glycopeptide. H, N and F stands for D-Mannose, N-Acetyl-D-Glucosamine and L-Fucose, respectively. **G. Glycoproteins potentially carrying paucimannose structures were predominantly associated with cytoplasmic translation processes in advanced stage tumours.** Cytoscape analysis of unique and overexpressed glycosignatures in advanced-stage tumors revealed significantly enriched pathways linked to cytoplasmic translation and rRNA binding ($p < 0.05$). In contrast, no significant pathways were identified for early-stage tumors.

MMP9 carries trimmed mannoses and links to poor prognosis

We assessed the cancer specificity of proteins elevated or exclusively expressed in advanced-stage patients, enriched via GNL, through an *in silico* analysis of their expression in healthy tissues using human proteome data. MMP9 emerged as the most cancer-specific protein, exhibiting minimal

expression in normal tissues, particularly in adipose tissues and immune cells of the bone marrow, pancreas, spleen, and colon (**Figures 5A-B and S11A-B**). In the gastric epithelium, it was mildly expressed in glandular cells and secretions (**Figure 5C**). On the other hand, MMP9 was detected in approximately 55% of the tumors analyzed in the GNL screening, exhibiting strong, widespread expression in the cytoplasm and plasma membrane of cancer cells with a diffuse tumor pattern (**Figure 5C**). It was also highly expressed in tumor-associated immune cells as well as in secretions within the extracellular matrix (**Figure 5C**). Notably, co-expression of MMP9 with GNL staining was observed in overlapping tumor regions in all MMP9 positive cases, encompassing both cellular and secretory compartments (**Figures 5D and S12**). For validation, we immunoprecipitated MMP9 from a tumour excision and analyzed it by mass spectrometry. Tandem mass spectrometry identified characteristic sugar residue fragments, further reinforced the presence of paucimannoses ($H_2N_2F_1$ and H_3N_2) at two of the three known glycosylation sites on MMP9 (Asn₁₂₀ and Asn₁₂₇; **Figures 5E and S13**). We conducted parallel analyses of multiple MMP9 and GNL overlapping areas in five tumors, including the one used for immunoprecipitation assays, as well as corresponding controls and healthy mucosa sections using double staining immunofluorescence. Consistent MMP9-GNL co-expression was observed in these areas, which was not evident in regions positive for only one of these molecules (**Figures 5D and S12**). Furthermore, analysis of healthy gastric mucosa revealed no evidence of abnormal MMP9 *N*-glycosylation (**Figures 5D and S12**), supporting the cancer-specific nature of this glycosylation signature.

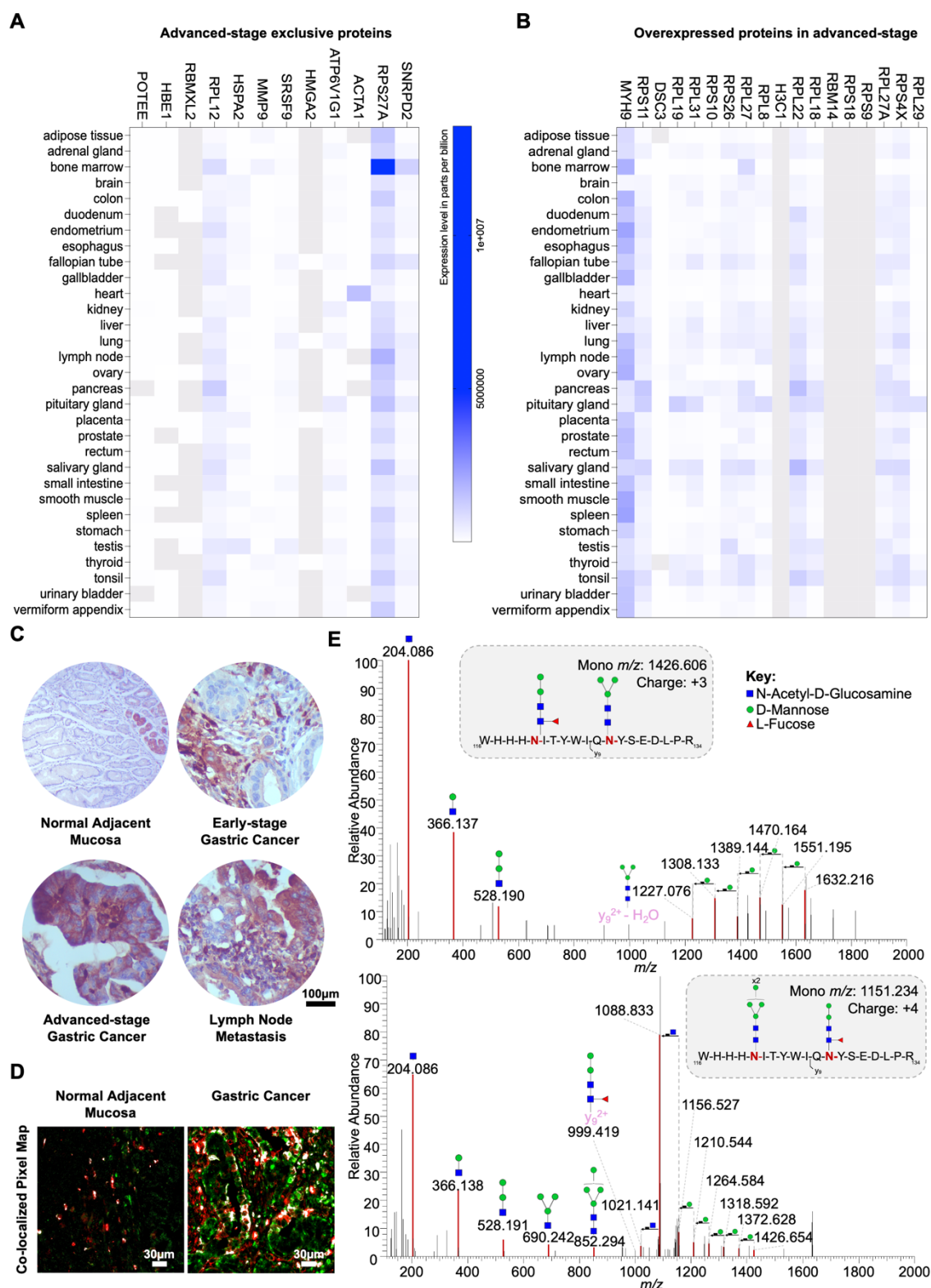


Figure 5. MMP9 is a key carrier of paucimannosidic *N*-glycans. A-B. *In silico* analysis of human proteome data highlights MMP9 as a highly cancer-specific protein. An analysis of human tissue proteomics data deposited in EMBL-EBI repository (accession PXD010154)

for GNL-enriched glycoproteins overexpressed (A) and/or exclusively (B) expressed in advanced GC cases highlights the high cancer specificity of MMP9, attributed to its reduced expression in healthy tissues. Residual levels of this protein were detected in the bone marrow, thyroid, and adipose tissue. Proteins with missing data (grey) were excluded from the analysis. **C. MMP9 is overexpressed in advanced-stage tumors and corresponding lymph node metastases compared to healthy tissues and early-stage lesions.** Expression of MMP9 is highly associated with aggressive forms of GC compared to early-stage tumours. Furthermore, it is more expressed in tumours in comparison to the healthy mucosa of non-cancer patients. In tumours, MMP9 was detected on the plasma membrane and cytoplasm of tumor cells, but also in the extracellular matrix (secreted MMP9). In the healthy stomach, its expression is circumscribed to the basal glandular component of gastric epithelium. **D. MMP9 and GNL staining are co-localized in the same tumor areas, suggesting the presence of MMP9 carrying paucimannoses.** MMP9 and GNL staining co-localize in the same tumor areas, suggesting that MMP9 carries paucimannoses. A co-localized pixel map, generated from double immunofluorescence analysis for MMP9 and GNL, revealed co-localized areas (grey/white spots) in tumor sections, in contrast to the normal adjacent mucosa. **E. MS/MS for MMP9 glycoproteoforms carrying paucimannose.** Briefly, MS/MS spectra of MMP9 glycoproteoforms isolated by immunoprecipitation from MMP9-GNL-positive tissues show that it carries $H_2N_2F_1$ and H_3N_2 paucimannosidic residues. MS/MS spectra support the existence of MMP9 peptides carrying paucimannosidic *N*-glycans at the Asn₁₂₀ and Asn₁₂₇ (upper panel) and Asn₁₂₇ (bottom panel). The upper spectrum presents the glycan oxonium ions at m/z 244.086, 366.137 and 528.190, and the bottom spectrum presents additional oxonium ions at m/z 690.242 and 852.294, according to the identified glycosylation pattern. Moreover, the spectra highlight the presence of peptide fragments carrying H_3N_2 ($y_9^{2+} - H_2O + H_3N_2$, upper panel) and $H_2N_2F_1$ ($y_9^{2+} + H_2N_2F_1$, bottom panel), reinforcing the presence of these paucimannosidic residues on MMP9. Additional losses of monosaccharide residues (mannose and HexNAc) were identified. H, N, and F represent D-Mannose, N-Acetyl-D-Glucosamine (HexNAc), and L-Fucose, respectively.

Clinically, MMP9 levels were significantly higher in advanced-stage compared to early-stage tumors (**Figure 6A**). Notably, MMP9 elevation was not associated with the presence of metastases or worse prognosis (**Figures 6A-B**). Nevertheless, we consistently observed weak to moderate, yet statistically significant correlations ($R = 0.2-0.4$; **Figure S14**) between MMP9 expression and all glycosyltransferases involved in *N*-glycan trimming (*HEXA*, *HEXB*, *MAN2A1*, *MAN2A2*, *MAN2B1*). This suggests a degree of co-regulation and

aligns with the presence of paucimannose structures in this glycoprotein. To further investigate the clinical relevance of aberrantly glycosylated MMP9, we employed double immunofluorescence assays, combining the detection of MMP9 and GNL lectin staining to assess their co-localization within tumor tissues. While this approach does not conclusively confirm specific *N*-glycan alterations in MMP9, when considered alongside our MS/MS data, it serves as a potential surrogate marker for aberrant glycosylation patterns in this glycoprotein. Based on this premise, we observed higher number of positive cases for MMP9-GNL in advanced-stage compared to early-stage tumors, with a trend toward further increases in T3 and a statistical relation with lymph node metastasis (**Figure 6C**). Furthermore, we found that this phenotype could accurately discriminate patients facing worst prognosis, when compared to assessing MMP9 alone (**Figure 6D**). Nevertheless, based on multivariate analysis, MMP9-GNL positivity was not an independent predictor of worse prognosis (data not shown). In summary, we emphasize the cancer-specific nature of MMP9 and underscore the potential of *N*-glycosylation, particularly the potential acquisition of trimmed glycosignatures, to enhance patient stratification strategies in gastric cancer.

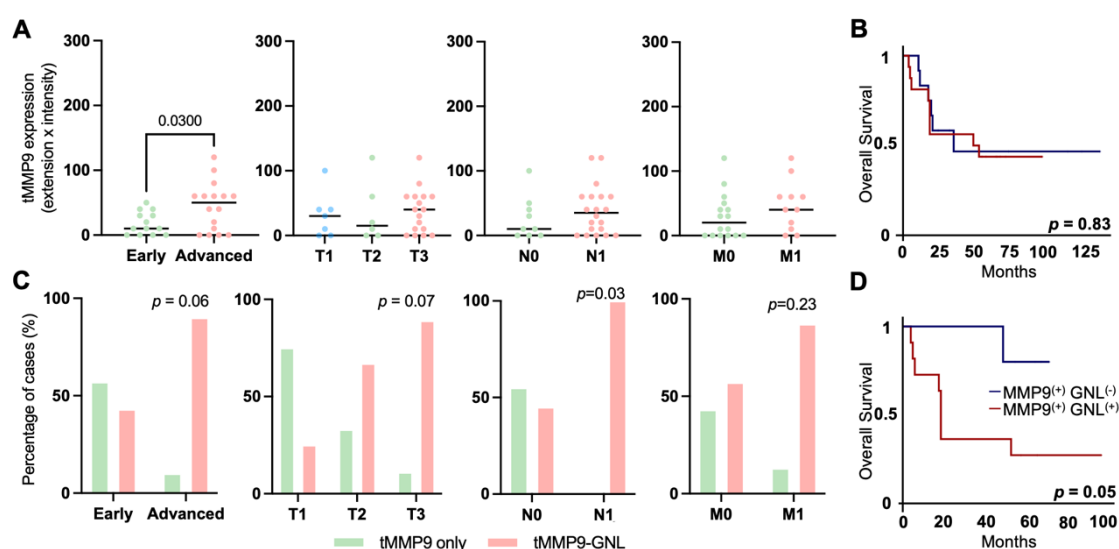


Figure 6. Abnormally glycosylated MMP9 associates with advanced metastatic tumors and poor prognosis. A. MMP9 expression in tumor cells increases in advanced-stage

tumors ($n = 30$, $p = 0.0300$), with no correlation to TNM classification ($p > 0.2000$). Statistical analyses included unpaired t-tests for early versus advanced-stage tumors, Mann-Whitney tests for N and M staging, and Brown-Forsythe and Welch ANOVA for mean differences across T stage groups (T1-T3). Outliers were removed using the ROUT method, and data normality was assessed with the Shapiro-Wilk test. Significance was set at $p < 0.05$.

B. MMP9 overexpression does not associate with worse prognosis ($p = 0.83$). The log-rank test was used to compare overall survival curves, while univariate analysis was applied to assess individual prognostic value.

C. MMP9-GNL positivity shows a trend toward association with cancer aggressiveness, including lymph node metastasis. The number of MMP9-GNL positive tumors tends to be higher in advanced-stage and high-grade tumors compared to MMP9-GNL negative tumors (early vs advanced stage: $p = 0.06$; T3 vs T1 and T2: $p = 0.07$). MMP9-GNL-positive cases were significantly higher among tumors presenting lymph node metastasis ($p = 0.03$). The chi-square test was implemented to determine the association between the presence of MMP9-GNL and relevant clinicopathological parameters.

D. Patients presenting the MMP9-GNL phenotype presented unfavorable prognosis compared to MMP9-GNL negative signatures ($p = 0.05$). The log-rank test was employed to compare overall survival curves, and univariate analysis to evaluate individual prognostic factors.

MMP9 for non-invasive GC detection

Finally, in an effort to translate these findings into a non-invasive setting, we screened the serum of gastric cancer patients and healthy individuals for MMP9 expression. MMP9 levels were significantly elevated in cancer patients compared to healthy controls ($p = 0.0002$), regardless of histological subtype, stage, or grade (**Figures 7A–F**). Although no statistically significant association with overall survival was observed ($p = 0.1795$; **Figure 7G**), a trend toward poorer outcomes in patients with higher serum MMP9 was noted. ROC curve analysis demonstrated moderate diagnostic performance, with an AUC of 0.7265 ($p = 0.0003$), a sensitivity of 87.5%, and a specificity of 51.28% (**Figure 7D**). These findings highlight the potential of serum MMP9 as a non-invasive biomarker for GC detection. Nevertheless, while its high sensitivity supports the identification of a substantial proportion of cancer cases, the relatively low specificity may

limit its standalone diagnostic value, particularly in distinguishing GC from benign or inflammatory conditions that also elevate MMP9 [75, 76]. In terms of prognostic value, ROC analysis indicated that MMP9 was not suitable for identifying aggressive disease or predicting poor outcomes, irrespectively of the histological subtype (data not shown). This, together with the lack of significant associations with tumor stage or survival, suggests that serum MMP9 may reflect systemic processes rather than tumor-specific aggressiveness. Nonetheless, its robust differential expression between cancer patients and healthy individuals supports its continued investigation, particularly as part of a combined biomarker panel to enhance diagnostic accuracy.

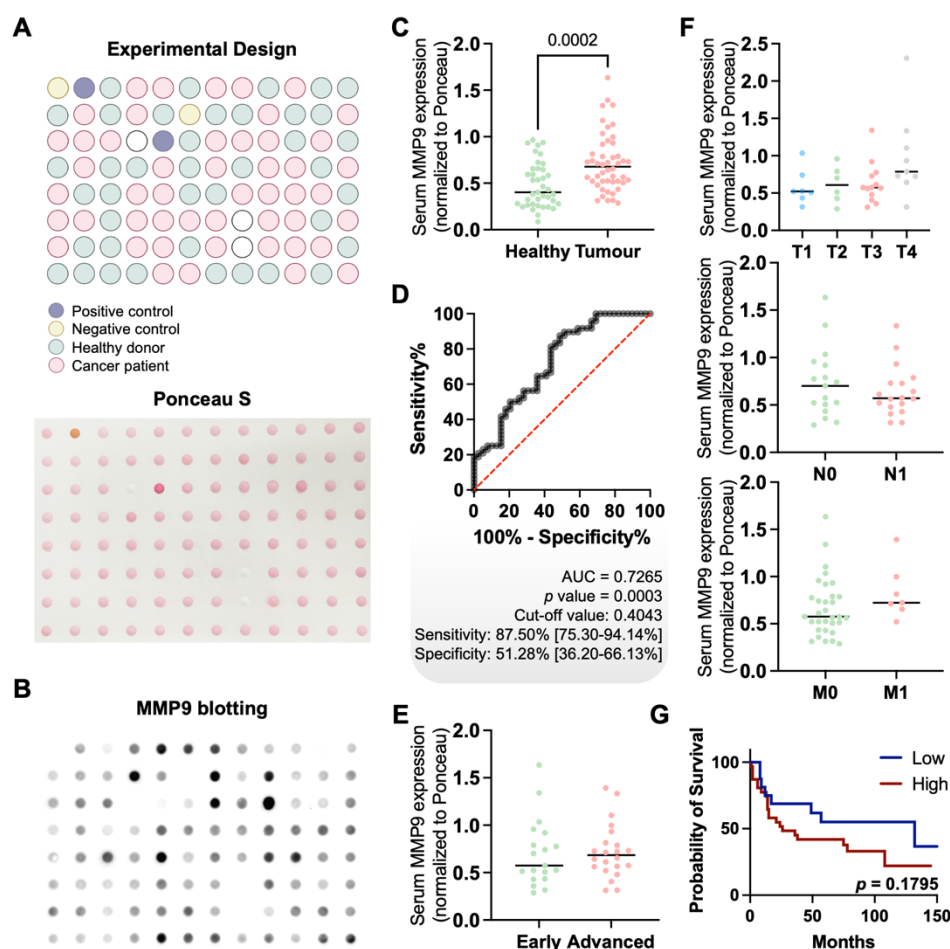


Figure 7. Serum MMP9 exhibits moderate discriminatory power between healthy individuals and cancer patients. A. Schematic representation of the layout of samples

on the Dot Blot membrane. Dot blot included scattered distribution of cancer patients' samples (pink, $n = 49$), healthy donors (green, $n = 40$) and experimental controls ($n = 4$). Positive and negative controls, comprising proteins extracted from tumour tissue previously evaluated by immunohistochemistry (positive and negative) or bovine serum albumin (negative), were included in experimental design. The Ponceau S staining image confirms uniform protein spotting across all samples. **B. MMP9 dot blotting reveals differential expression levels among samples, with overexpression of MMP9 in cancer patients' serum samples.** Representative illustration of MMP9 immunoblot showing stronger signals in cancer patients compared to healthy donors, validated with accurate positive and negative controls. **C. Cancer patients present increased levels of serological MMP9.** MMP9 was significantly elevated in the serum of cancer patients compared to healthy donors ($p = 0.0002$, Mann-Whitney test). Quantification of MMP9 levels in serum was normalized to Ponceau S. **D. Serological MMP9 exhibits high diagnostic accuracy, distinguishing healthy donors from cancer patients.** The ROC (Receiver Operating Characteristic) curve for serological MMP9 demonstrated a moderate discrimination ability, with an AUC (Area Under the Curve) of 0.7265 ($p = 0.0003$, $n = 89$), yielding a sensitivity of 87.5% and specificity of 51.28%. The black ROC curve illustrates biomarker performance, with the red diagonal line representing the reference for a random classifier. The optimal cut-off value was determined using Youden's index, and statistical significance was defined as $p < 0.05$. **E and F. Serum MMP9 levels show no significant correlation with the clinicopathological parameters of cancer patients.** No significant correlation was observed between serum MMP9 levels and clinical stage (E) or TNM classification (F), although a trend toward higher MMP9 expression in more advanced disease stages was noted (clinical stage, $n = 42$; TNM classification, $n = 40$). A Mann-Whitney test was used to compare serum MMP9 levels between early and advanced-stage tumours. Brown-Forsythe and Welch ANOVA, T test with Welch's correction and Mann-Whitney tests were used to compare the distribution of MMP9 levels across T, N and M stages, respectively. **G. Elevated serological MMP9 levels trend towards reduced overall survival.** Kaplan-Meier survival analysis comparing patients with high versus low serum MMP9 levels showed a trend toward poorer survival in the high MMP9 group, though not statistically significant ($n = 49$, $p = 0.1795$). Optimal cut-off was defined as the optimal discriminate value in a survival ROC curve. Log rank tests was used to compare overall survival curves. Statistical significance was set at $p < 0.05$. Before performing statistical tests, outliers were removed using the ROUT method ($Q = 1\%$), and data normality was assessed with the Shapiro-Wilk test.

Building on these observations, we further investigated the relationship between serum MMP9 levels and serum GNL expression. No significant correlation was observed between the two biomarkers (**Figure S15**), indicating that they likely capture different aspects of gastric cancer biology. While MMP9 may be more reflective of systemic processes, GNL expression appears to be closely associated with tumour-specific glycosylation patterns, which warrants future investigations. Notably, while GNL has proven effective in detecting a range of mannose-rich structures, its broad binding profile, including hybrid and oligomannose *N*-glycans, may limit its ability to selectively identify specific MMP9 glycoforms of clinical interest. Future studies should aim to define cancer-specific MMP9 glycoproteoforms with higher precision to enhance the specificity of non-invasive detection strategies

Discussion

This study significantly advances our understanding of GC glycobiology by revealing novel glycosidic signatures associated with cancer aggressiveness. We observed a significant enrichment of paucimannosidic *N*-glycans in advanced GC, a glycosylation profile not previously linked to this cancer type. While paucimannosylation was once considered limited to invertebrates and plants, its presence in various human tissues, including stem cells, highlights its potential role in cellular development [17, 77]. Moreover, its recent association with various pathologies, including several cancers, systemic lupus erythematosus, and inflammatory conditions, indicates a complex interplay between paucimannosylation and disease [18, 21, 77, 78]. This study reveals a novel link between paucimannosidic glycans and adverse outcomes in GC, highlighting their potential as biomarkers for disease progression and prognosis. While our findings establish a clear association between paucimannosylation and GC aggressiveness, the functional role of these truncated *N*-glycans in GC remains poorly understood. As such, no direct studies currently address the biological

consequences of paucimannosylation in this context. However, reports from other cancer types and inflammatory conditions have shown that paucimannoses can modulate immune responses via interactions with receptors like DC-SIGN and the mannose receptor, and may also impact protein trafficking, receptor stability, and cell signaling [19, 23, 26]. Although speculative in the context of GC, similar mechanisms could be envisaged, especially considering the observed enrichment in aggressive tumors. These hypotheses warrant future dedicated functional studies to dissect the biological roles of these glycan structures in GC pathogenesis. Beyond paucimannosylation, a wide spectrum of glycosylation alterations has been documented in GC. Notably, hypersialylation, particularly by overexpression of terminal sLe antigens, has been associated with tumor invasion, immune evasion, and metastasis [29, 30]. Complex *N*-glycans with increased branching and terminal sialic acids have also been linked to aggressive disease phenotypes. Likewise, glycan traits such as core fucosylation and bisecting GlcNAc have shown context-dependent roles, sometimes even exerting tumor-suppressive effects [40-43]. These diverse and sometimes opposing glycan signatures underscore the intricate regulation of glycosylation in cancer biology. Our findings expand this landscape by highlighting the prognostic relevance of trimmed *N*-glycans, specifically paucimannoses, which remain understudied despite their consistent association with aggressiveness in our GC cohort. Furthermore, we found that the overexpression of multiple glycosidases involved in paucimannose formation in gastric tumours was significantly associated with aggressiveness and paucimannose increase. Specifically, enzymes such as α -mannosidases, which trim high-mannose structures to form paucimannose glycans, showed increased expression in more advanced stages, associating with paucimannose expression. Future studies should elucidate the specific molecular pathways mediating this link and explore the therapeutic and prognostic potential of targeting the glycosomes responsible for *N*-glycan trimming in GC.

Intriguingly, we found that paucimannosidic *N*-glycans are predominantly present in intracellular ribosomal proteins, challenging the traditional view of *N*-glycosylation as a phenomenon limited to the cell surface. This discovery opens new avenues for research into the role of intracellular glycosylation in cancer biology. The presence of these glycans on ribosomal proteins suggests a potential involvement in regulating protein synthesis or ribosome assembly, which could significantly impact cellular processes in cancer cells, warranting further investigation. Nevertheless, we also observe the presence of these glycans on membrane proteins such as CEACAM6 and MMP9, two glycoproteins frequently linked to GC aggressiveness [79-82]. Here, we focused on MMP9, a zinc-dependent metalloproteinase that plays a pivotal role in the extracellular matrix [83]. MMP9 has been implicated in tumor invasion by degrading the basement membrane, which acts as the first barrier against cancer dissemination across various tumor types [83, 84]. Our *in silico* analysis of the human proteome further demonstrated that MMP9 exhibits a restricted expression pattern in healthy tissues, underscoring its potential for precise cancer targeting. In our study, we found that MMP9 levels are significantly elevated in gastric cancer tissues compared to adjacent normal mucosa. Furthermore, increased MMP9 expression correlates with disease stage and grade, and is associated with poor prognosis. These findings align with observations from other studies, underscoring the critical role of MMP9 in the progression and aggressiveness of GC [79, 80]. Notably, we also found that MMP9 serves as a major carrier of paucimannoses, supporting that this specific glycosignature could be instrumental in identifying patient subsets with metastasis and worse prognostic outcomes. The paucimannosylation of MMP9 may also have significant implications for its function in GC progression. We speculate that these truncated glycan structures could affect MMP9's enzymatic activity, stability, or interactions with other extracellular matrix components. While further studies are needed to elucidate the functional implications of *N*-glycome remodeling on MMP9 functionality and its role in cancer progression, our findings underscore the

importance of this glycoprotein's glycosylation in precise patient stratification and cancer targeting. The association between paucimannosylation and GC aggressiveness also suggests potential targeted therapeutic strategies.

Building on glycomics data, we further used GNL to evaluate paucimannosidic *N*-glycans in GC tissues. This approach was particularly suitable in this context, as oligomannose structures, which are also recognized by GNL, did not show significant variation during disease progression. Accordingly, we observed increased GNL staining associated with intestinal-type gastric cancer aggressiveness and a significant correlation with poorer prognosis. Furthermore, GNL demonstrated superior prognostic performance when compared to classical biomarkers routinely used in clinical practice, including E-cadherin, p53, and MSI. It also outperformed the well-established cancer-associated glycans sLeA and sTn, further reinforcing its association with aggressive tumor behavior in this subtype. Additionally, elevated GNL reactivity in mixed-type tumors suggests its potential for stratifying this challenging and poorly defined subgroup, where reliable biomarkers are limited. These findings support the use of GNL as a promising tissue-based biomarker with potential applicability across multiple histological subtypes. Notably, glycosylation is known to be influenced by various genetic and environmental factors, including smoking, alcohol consumption, and family history [85-88]. However, detailed clinical information on these variables was not uniformly available across our cohort, limiting our ability to assess their specific impact in this study. These factors should be addressed more comprehensively in future studies integrating clinical and molecular data to better inform potential clinical translation. Nevertheless, to explore non-invasive clinical applications, we extended our analysis to serum samples. However, GNL showed limited utility in this setting, likely reflecting the challenges of using lectins with broad specificity to detect low-abundance, disease-associated glycans in circulation. This limitation underscores the need for comprehensive serum glycomics analyses in gastric cancer, which

remain largely underexplored. In contrast, MMP9 demonstrated moderate diagnostic potential in serum, supporting its value as a candidate for further investigation. Interestingly, we did not observe significant associations with advanced disease features such as stage or lymph node metastasis, as previously reported by other studies [89, 90]. Notably, elevated serum MMP9 has also been documented in benign inflammatory conditions, including inflammatory bowel disease, autoimmune disorders such as type 1 diabetes and rheumatoid arthritis, as well as in acute inflammatory settings like ARDS and COVID-19, warranting cautious interpretation in future studies [75, 76, 91]. Although we attempted to correlate serum MMP9 levels with GNL reactivity to enhance its predictive value, no significant association was observed. This may reflect the limited specificity of GNL in the serum setting, where it likely fails to selectively detect the glycoforms of interest, in contrast to its performance in tissue-based applications. Nevertheless, our findings from GNL-enrichment-based tissue glycoproteomics suggest that MMP9 may carry disease-relevant glycoforms with potential clinical utility. Therefore, future efforts should focus on characterizing cancer-specific MMP9 glycoforms to enhance specificity and clinical relevance. Targeting such glycoproteoform signatures, rather than relying on general glycan-binding probes, holds strong promise for advancing precision, non-invasive biomarker strategies in GC.

Concluding Remarks

In summary, these findings reveal promising glycan-based biomarkers for enhanced prognostic stratification in gastric cancer, particularly within the intestinal subtype, which can be detected using GNL. The close association between paucimannosylation, MMP9 expression, and tumor aggressiveness underscores the complexity of glycoproteome remodeling and highlights the potential of glycan-focused approaches to improve patient management. These insights are especially valuable in light of the current lack of robust prognostic tools for histologically defined subgroups. Future research

should aim to validate these findings in larger, independent cohorts, investigate the functional impact of *N*-glycan alterations, particularly in relation to MMP9 biology, and explore the therapeutic relevance of glycan signatures, including their potential integration into theranostic strategies.

Abbreviations

AGC: Automatic Gain Control; BSA: Bovine Serum Albumin; DAPI: 4',6-Diamidino-2-phenylindole dihydrochloride; DTT: Dithiothreitol; EICs: Extracted Ion Chromatograms; FFPE: Formalin-Fixed Paraffin-Embedded; GC: Gastric Cancer; GDC: Genomic Data Commons; GNL: Galanthus Nivalis Lectin; GO: Gene Ontology; HCD: Higher energy Collisional Dissociation; NCE: Normalized Collision Energy; PCAWG: International Cancer Genome Project's Pan-Cancer Analysis of Whole Genomes; qPCR: Quantitative Polymerase Chain Reaction; RNA: Ribonucleic Acid; rRNA: Ribosomal Ribonucleic Acid; sTn: sialyl-Tn; TCGA: The Cancer Genome Atlas; TFA: Trifluoroacetic Acid.

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Author Contributions

Conceptualisation: DF and JAF; Methodology: DF, BMS, MRS, BO, AB, JAF; Software: MRS, JAF; Validation: DF, MRS, BO, LPA, LLS, JAF; Investigation: DF, BMS, MRS; Resources: DF, BO, LPA, LLS, JAF; Data Curation: DF, BMS, MRS, BO, AB, LPA, JAF; Writing- Original Draft: DF and JAF; Writing- Review & Editing: MRS and LLS; Visualization: DF, BMS, MRS, BO; Supervision: JAF; Project Administration: JAF; Funding Acquisition: LLS and JAF.

Competing interests

JAF is the founder and CEO of GlycoMatters Biotech. LLS is also one of the founders of the company.

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Supporting Information

Additional Supporting Information may be found online in the supporting information tab for this article.

Trimmed *N*-Glycans Define Aggressive Gastric Cancer and Predict Clinical Outcomes

Supplementary Information

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Running Title: Trimmed *N*-Glycans as Biomarkers of Aggressive Gastric Cancer

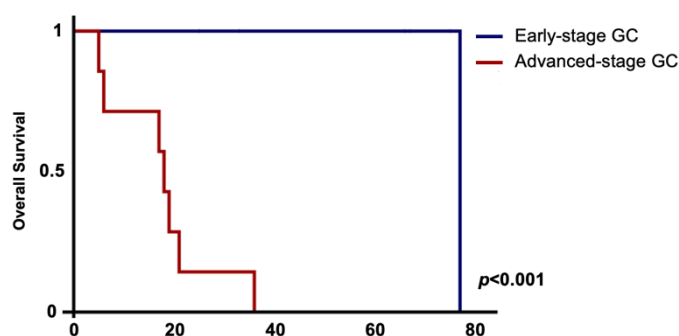


Figure S1. Patients with advanced disease exhibit poorer overall survival ($p < 0.001$). Overall survival was defined as the period between the date of surgery and the date of patient death. Log rank test was used to compare overall survival curves, with statistical significance defined as $p < 0.05$.

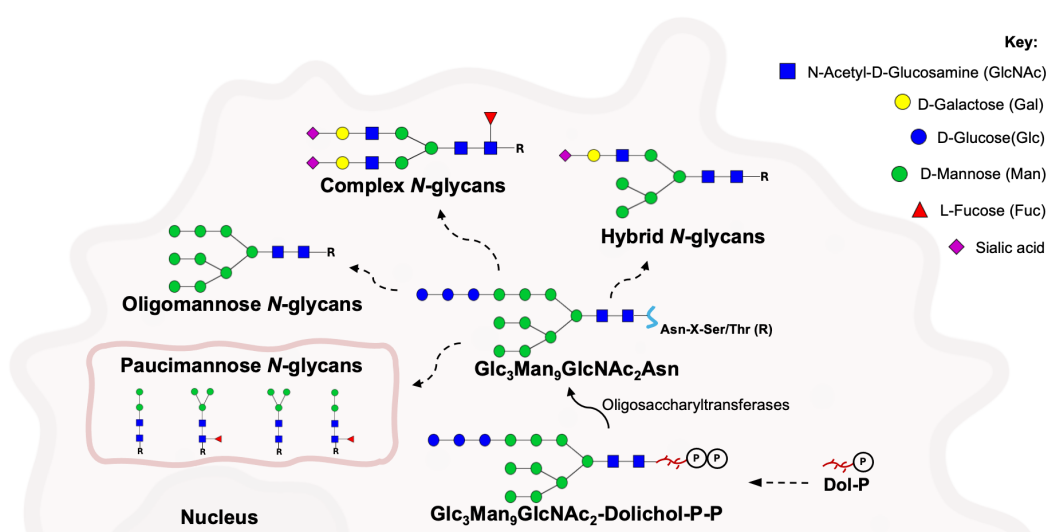


Figure S2. Schematic representation of general pathways of protein-associated *N*-glycan biosynthesis. At the endoplasmic reticulum (ER), the precursor $\text{Glc}_3\text{Man}_9\text{GlcNAc}_2\text{-P-P-Dol}$ is transferred to asparagine (Asn) in Asn-X-Ser/Thr proteins sequence by oligosaccharyltransferases. Notably, “X” represents any amino acid, except proline (Pro). $\text{Glc}_3\text{Man}_9\text{GlcNAc}_2\text{Asn}$ is further processed in the ER and Golgi apparatus given rise to oligomannose, paucimannoses, hybrid and complex *N*-glycans.

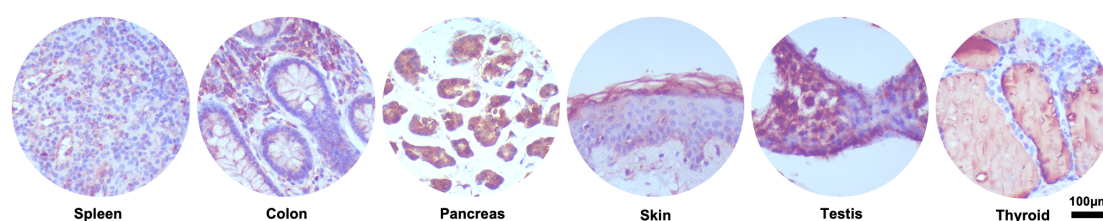


Figure S3. GNL-ligands present a restricted expression pattern in healthy tissues. These are mainly found in pancreas, immune cell populations and testis. Staining was found mainly in the cytoplasm of pancreatic exocrine cells, testicular germ cells, colonic intraepithelial immune cells and in less extension in the basal and keratin layers of epidermis. Staining on thyroid colloid was disregarded.

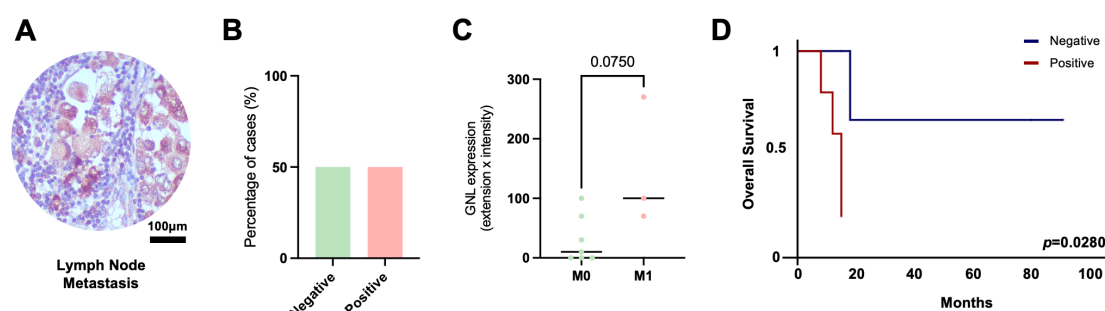


Figure S4. Presence of GNL-ligands on lymph node metastases is a marker of poor prognosis in GC. **A and B.** GNL staining was primarily observed in the cytoplasm, with a lesser extent on the plasma membrane of tumor cells, in half of the analyzed lymph node metastases ($n = 10$). **C.** A trend towards overexpression of GNL staining was observed in lymph node metastases of metastatic tumors ($p = 0.0750$). Mann-Whitney test was used to compare GNL expression distribution between non-metastatic (M0) and metastatic tumors (M1), after outliers' removal and data normality determination (Shapiro-Wilk). Significance was considered when $p < 0.05$. **D.** Patients expressing GNL staining in lymph node metastases present worst overall survival ($p = 0.0280$) compared with negative cases in the univariate analysis. Mantel Cox test was used to compare overall survival curves. $P < 0.05$ was set as the threshold for statistical significance.

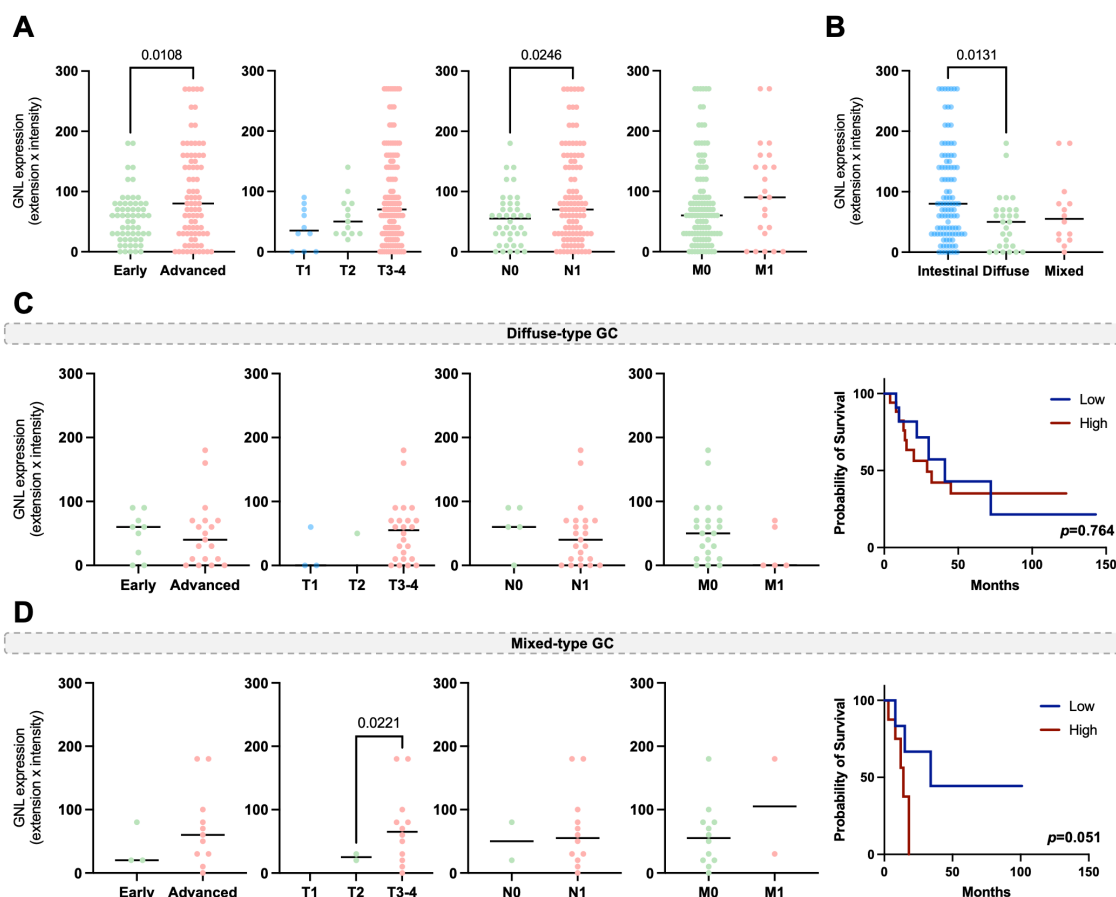


Figure S5. Advanced-stage intestinal-type GC tumours exhibit elevated expression of GNL ligands. **A.** GC tumours with regional lymph node metastasis exhibit significantly higher levels of GNL ligands. Advanced-stage GC tumours showed significantly higher levels of GNL ligands ($p = 0.018$), with a correlation observed between increased GNL expression in primary tumours and the presence of lymph node metastasis ($p = 0.0246$). No significant association with T stage or distant metastasis was observed ($n = 148$). Mann-Whitney and Kruskal-Wallis's tests were implemented to assess the distribution of GNL ligand levels across different stages and metastasis statuses. **B.** Intestinal-type GC tumours demonstrate higher GNL expression compared to diffuse-type tumours ($n = 144$). Kruskal-Wallis' s test was used to compare GNL expression across Lauren's classification groups. **C.** The expression of GNL ligands in diffuse-type GC do not correlate with clinicopathological parameters or prognosis ($n = 29$). Mann-Whitney and Kruskal-Wallis tests were used to compare groups. Log-rank test was used to compare survival distribution between groups. **D.** Advanced T-stage mixed GC tumours present higher levels of GNL. GNL expression levels were found significantly increased in T3-4 stage tumours ($p = 0.0221$), however no significant differences were observed based on metastasis status ($n = 14$). A trend towards worse overall survival was noted in mixed GC patients showing overexpression of GNL-ligands ($p = 0.051$). Unpaired t-test with Welch correction was applied to compare variable distribution among groups. The log-rank test

was employed to compare overall survival curves. Statistical significance was considered when $p < 0.05$. Statistical testing was preceded by the removal of outliers using the ROUT method ($Q = 1\%$) and an assessment of data normality with the Shapiro-Wilk test.

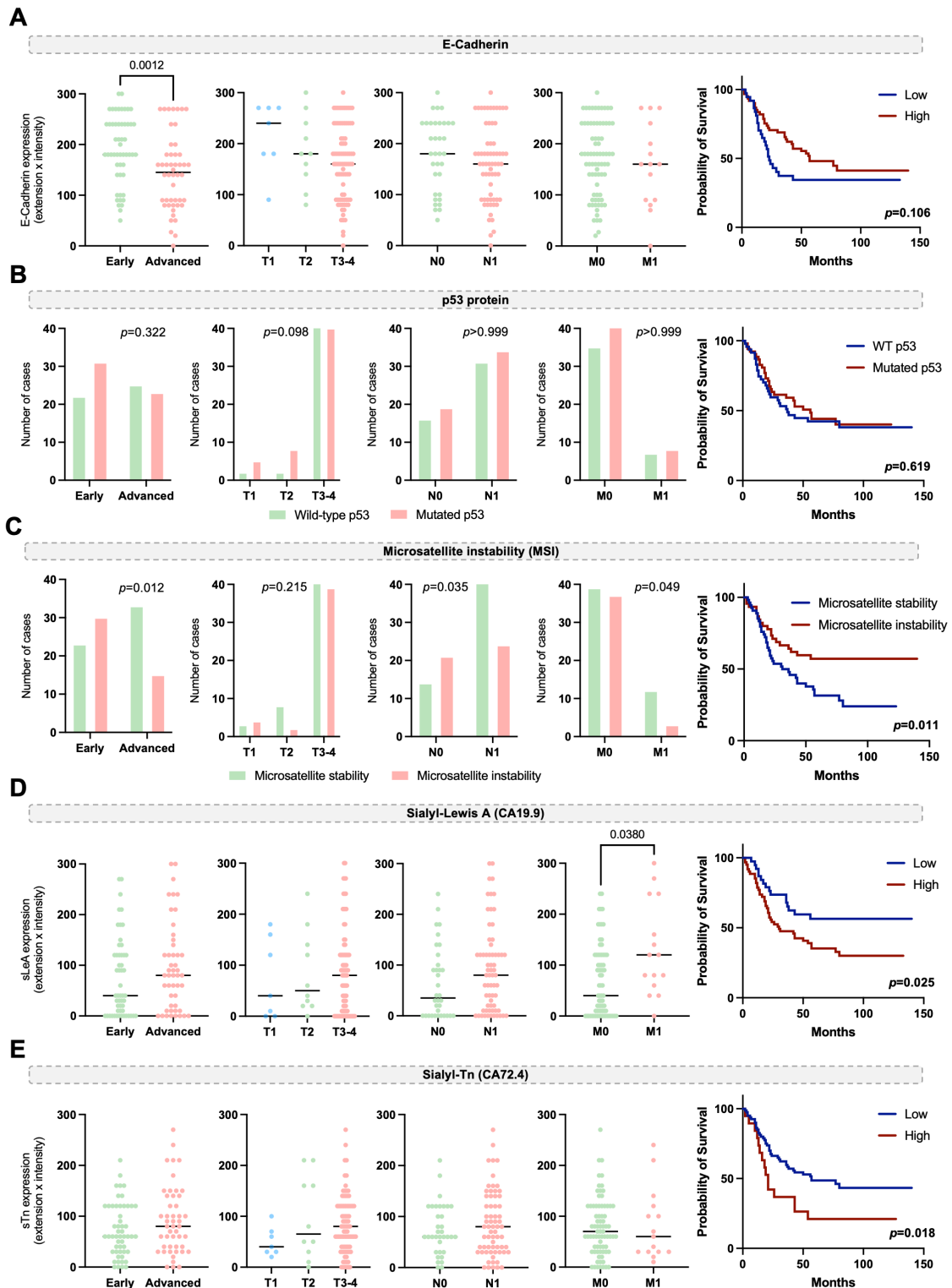


Figure S6. GC classical biomarkers in intestinal-type GC tumours present limited clinical value. A. Advanced-stage GC tumours show reduced levels of E-cadherin, an important protein linked to cell-cell adhesion. E-Cadherin expression was significantly lower in advanced-stage tumors ($p = 0.0012$), but no statistically significant associations were observed across T, N, or M stages ($n = 100$). Kaplan-Meier survival analysis indicated no significant difference in overall survival between patients with high versus low E-

Cadherin expression ($p = 0.106$). Mann-Whitney and Kruskal-Wallis' tests were implemented to compare E-cadherin levels among groups. Log rank test was used to compare overall survival curves. **B. Mutation status of p53 is not significantly associated with any clinical or pathological variables.** No significant associations were observed across clinical variables, neither in survival ($n = 101$). Chi-square was used to determine the association between the presence of mutations on p53 and relevant clinicopathological parameters. Differences in patient survival across groups were assessed via log-rank testing. **C. Microsatellite instable tumours are linked to less aggressive traits and better prognosis.** MSI was significant more frequently in early-stage tumours ($p = 0.012$), especially in non-metastatic tumours (N, $p = 0.035$; M, $p = 0.049$; $n = 101$). Additionally, MSI status was significantly associated with improved overall survival ($p = 0.011$). Associations between MSI status and clinicopathological parameters were analyzed using the chi-square test. Kaplan-Meier survival analysis with log-rank testing was conducted to compare patient survival across defined groups. **E. Metastatic intestinal-type GC tumours overexpress the Sialyl Lewis A antigen (sLeA), glycosignature linked with poor prognosis.** Significantly elevated sLeA expression was observed in tumours with clinical evidence of distant metastasis ($p = 0.038$, $n = 101$). Kaplan-Meier survival analysis revealed a significant association between high sLeA expression and reduced overall survival ($p = 0.025$). Comparison of sLeA expression levels among groups was performed through Mann-Whitney and Kruskal-Wallis tests. Log rank test was used to compare overall survival curves. **F. Increased levels of sTn are significantly associated with worst prognosis in intestinal-type GC tumours.** Expression of sTn in GC didn't presented significant differences across clinical stages or TNM classification ($n = 101$). However, increased levels of sTn were significantly associated with worse overall survival ($p = 0.018$). To assess differences in sTn distribution between groups, the non-parametric Mann-Whitney test (for pairwise comparisons) and Kruskal-Wallis' test (for multiple group comparisons) were applied. Survival analysis using Kaplan-Meier estimation, followed by log-rank testing, was conducted to compare survival outcomes across the defined patient groups. P values < 0.05 were considered statistically significant. Outliers were removed using the ROUT method ($Q = 1\%$) before statistical testing, and data normality was verified through the Shapiro-Wilk test.

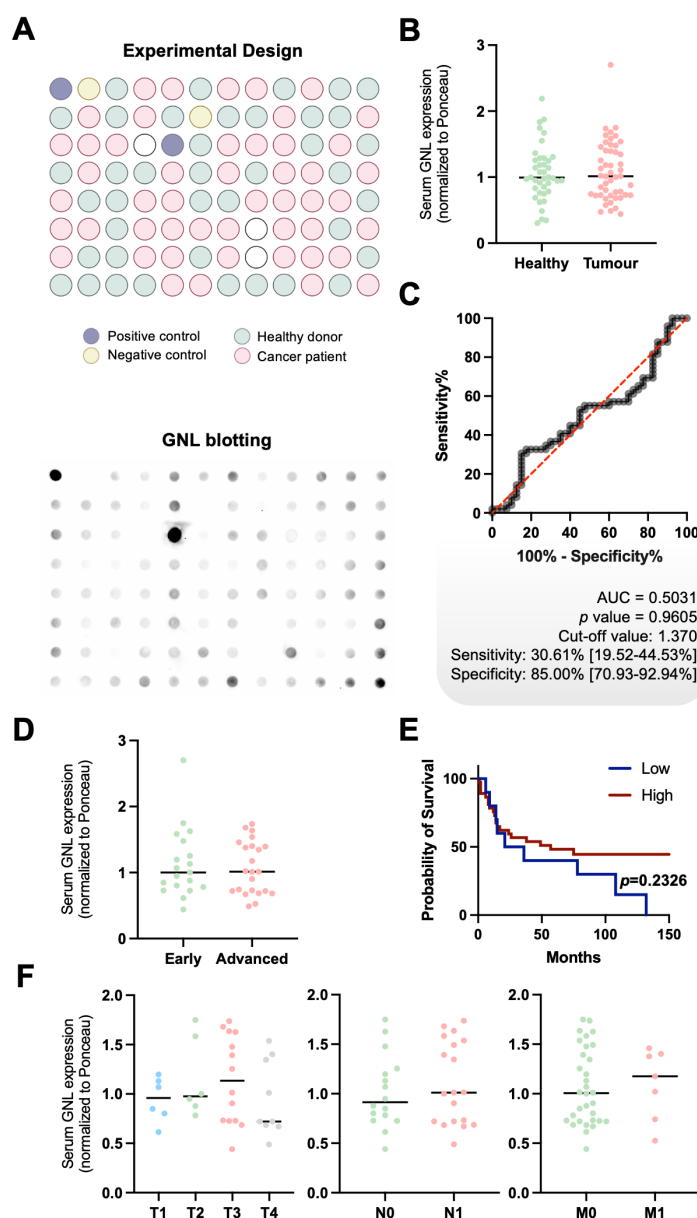


Figure S7. Serum GNL measurement does not exhibit significant discriminatory capability. **A.** GNL dot blotting reveals no clear differentiation between samples. Blotting for biotinylated GNL unveiled no clear pattern of staining (n = 89). The Dot Blot includes a dispersed arrangement of cancer patient samples (pink, n = 49), healthy donor samples (green, n = 40), and experimental controls (n = 4). Positive controls, consisting of proteins extracted from tumour tissue previously assessed by immunohistochemistry, and negative controls (PNGase F-treated samples or bovine serum albumin), were incorporated into the experimental design. **B.** Healthy donors and cancer patients present similar profiles regarding GNL expression in serum. No significant difference was observed between healthy donors and cancer patients (n = 89). Mann-Whitney test was used to assess differences on GNL levels distribution between healthy donors and cancer patients. **C.** Serum GNL levels do not discriminate healthy donors from cancer patients. ROC curve

highlighted no discriminatory power of serum GNL levels, with an AUC of 0.5031 ($p = 0.9605$). The black ROC curve shows the biomarker's performance, with the red diagonal line indicating the reference for a random classifier. The optimal cut-off value was determined using Youden's index, and statistical significance was defined as a p value < 0.05 . **D, E and F. Serological GNL levels do not correlate with clinicopathological features or prognosis.** No significant correlation was observed between serum GNL levels and clinical stage (D, $n = 42$), prognosis (E, $n = 48$, $p = 0.2326$) or TNM classification (F, $n = 40$). Mann-Whitney test was used to compare GNL expression among clinical stage (D), N and M stage (F), while Ordinary one-away ANOVA test was used to compare the levels of GNL among T stages (F). Kaplan-Meier survival analysis with log-rank tests was performed to compare patient survival between the defined groups. Optimal cut-off was defined as the optimal discriminate value in a survival ROC curve. Statistical significance was considered when $p < 0.05$. Prior to statistical tests, outliers' removal (ROUT method, $Q = 1\%$) and data normality assessment (Shapiro-Wilk test) were applied.

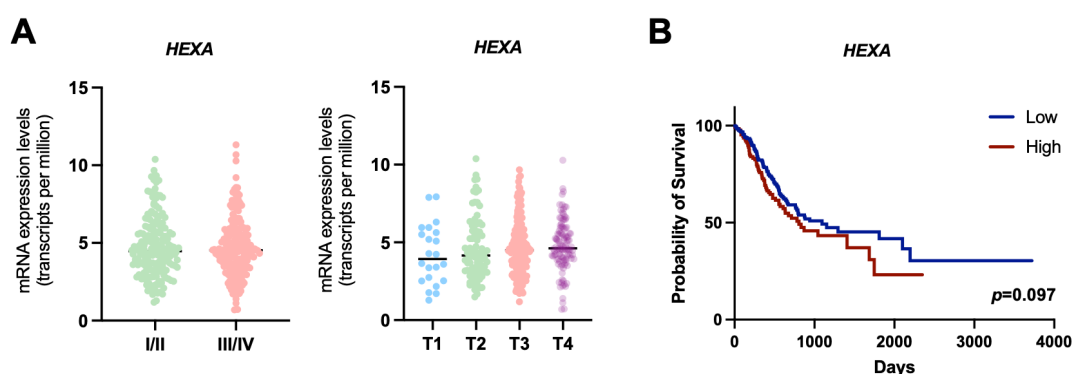


Figure S8. *HEXA* mRNA levels do not change with tumor progression. A. *HEXA* expression (according to TCGA data) does not change with disease progression. Mann-Whitney and Kruskal-Wallis' tests were used to compare the distribution among groups. ROUT method and Shapiro-Wilk tests were performed to remove outliers and determine data normality, respectively. Statistical significance was considered when $p < 0.05$. **B. Tumours exhibiting higher levels of *HEXA* tend to present worst prognosis ($p = 0.097$).** Log rank test was implemented to compare overall survival curves. Results were considered statistically significant if $p < 0.05$.

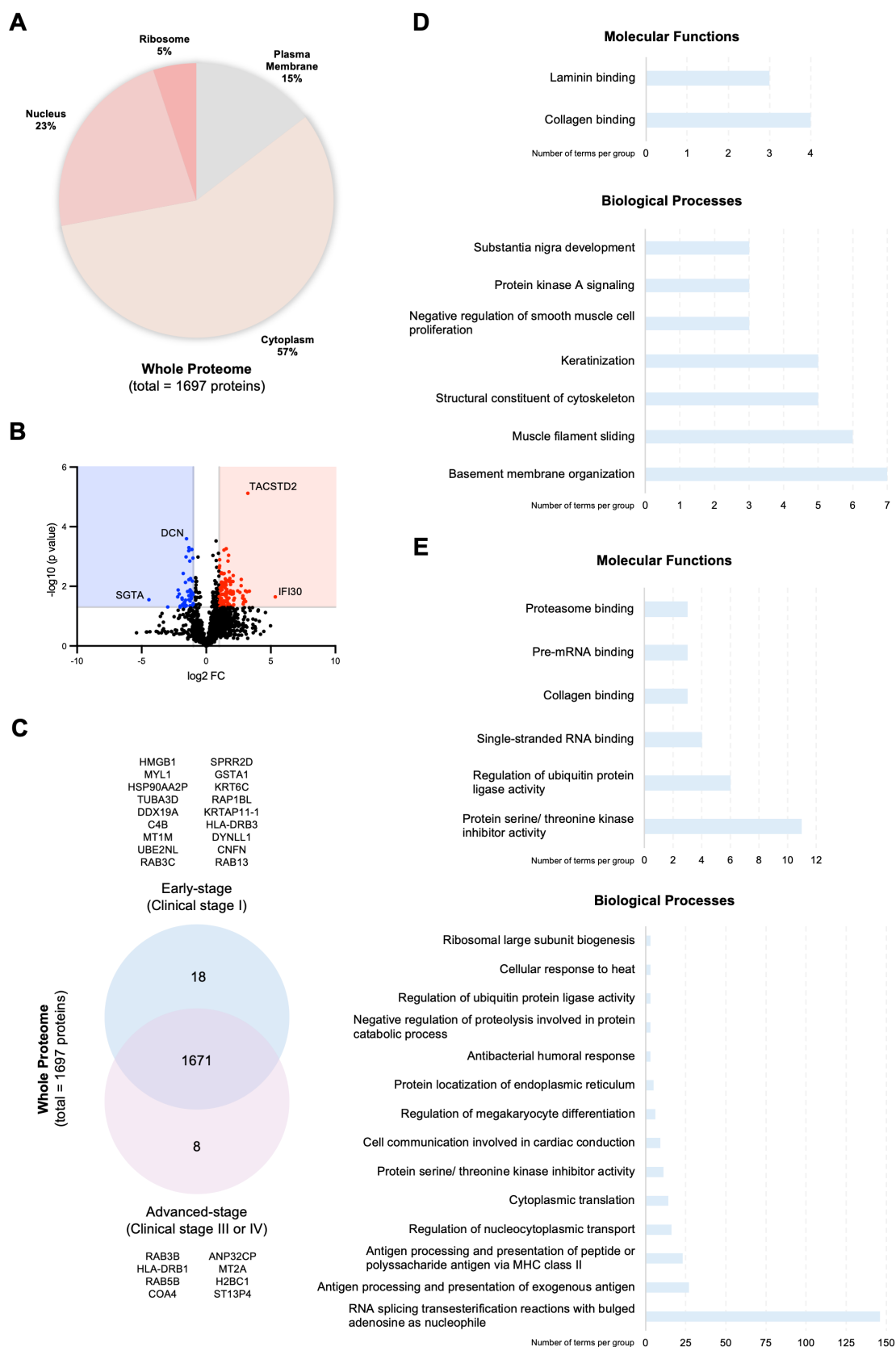


Figure S9. Advanced-stage GC tumors exhibit extensive proteome remodeling. A. Over 1600 proteins were identified across all cell organelles. Identified proteins (n = 1697) were primarily localized to the cytoplasm (57%), nucleus (23%), and plasma membrane (15%)

of tumor cells. A small proportion of ribosomal proteins (5%) were also identified. **B. Scatter plot analysis reveals significant proteomic remodeling with tumor progression.** Advanced-stage tumors overexpress 111 proteins, such as IFI30 and TACSTD2 (red), while early-stage tumors display increased levels of 48 proteins, including SGTA and DCN (blue). **C. Opposing clinical stages exhibit distinct proteomic signatures.** A Venn diagram highlights 8 proteins exclusively expressed in advanced-stage tumors (e.g., RAB3B, HLA-DRB1, and COA4) and 18 proteins unique to early-stage tumors (e.g., HMGB1, MYL1, and C4B). A high degree of homology was also observed, with both stages co-expressing 1671 at variable levels. **D-E. Proteome characterization evidences stage-specific molecular and biological functions.** GO term analysis using Cytoscape highlights that early-stage GC tumors are enriched in proteins involved in extracellular binding, cell adhesion, cytoskeletal remodeling, and substantia nigra development (D). Late-stage tumors are enriched in glycoproteins associated with cellular processes such as RNA splicing and antigen processing and presentation (E). Only pathways with statistical significance ($p < 0.05$) were considered.

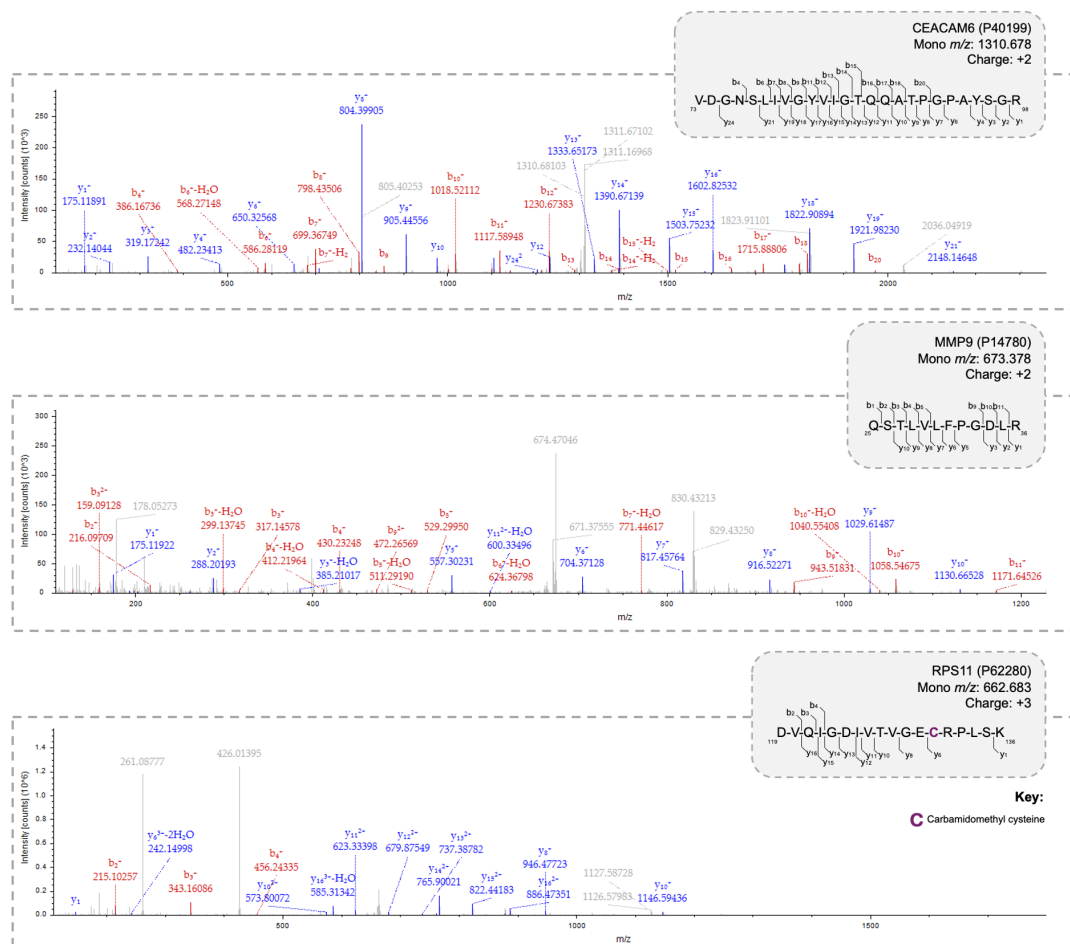


Figure S10. MS/MS spectra support the existence of non-glycosylated peptides of CEACAM6 (P40199), MMP9 (P14780) and RPS11 (P62280) in GC tumour tissues. MS/MS

spectra showing well-defined b- and y-ion series, providing high confidence in peptide sequence and protein assignment. The detection and identification of non-glycosylated peptides from CEACAM6, RPS11, and MMP9 further strengthen and validate the identification of these proteins in the glycoproteomic analysis.

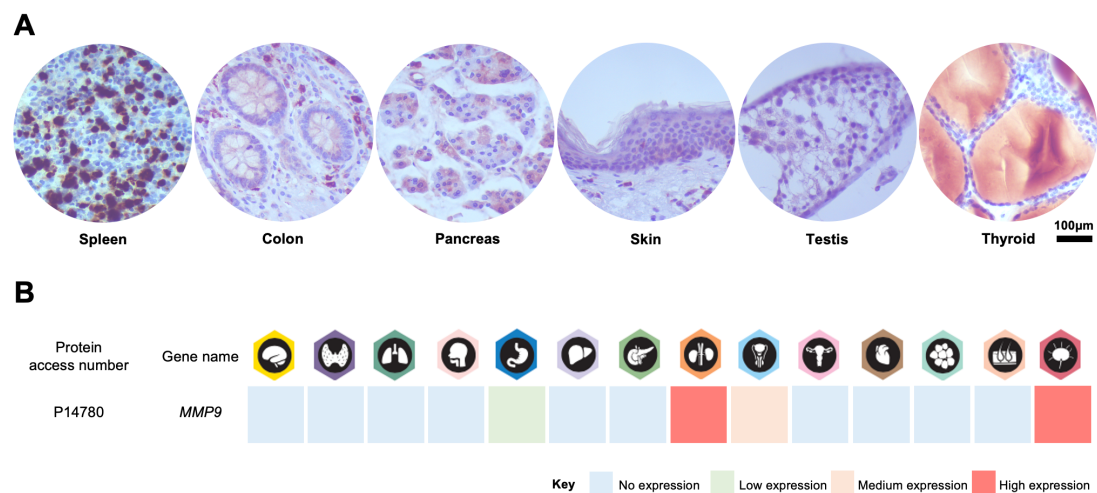


Figure S11. MMP9 expression in healthy tissues is highly restricted to a subset of immune cells. A. MMP9 expression in healthy tissues was restricted to a subset of immune cells in the spleen and colonic intraepithelial immune cells. Residual cytoplasmic expression on exocrine pancreas was observed. Our data highlighted no expression of MMP9 in the skin, testis or thyroid. B. The Human Protein Atlas database supports the existence of limited MMP9 expression in healthy tissues. MMP9 was particularly evident in the urinary tract (microvilli of proximal tubules), lymphoid organs and testis. Residual expression in mucosal lymphoid cells in colon was also noted.

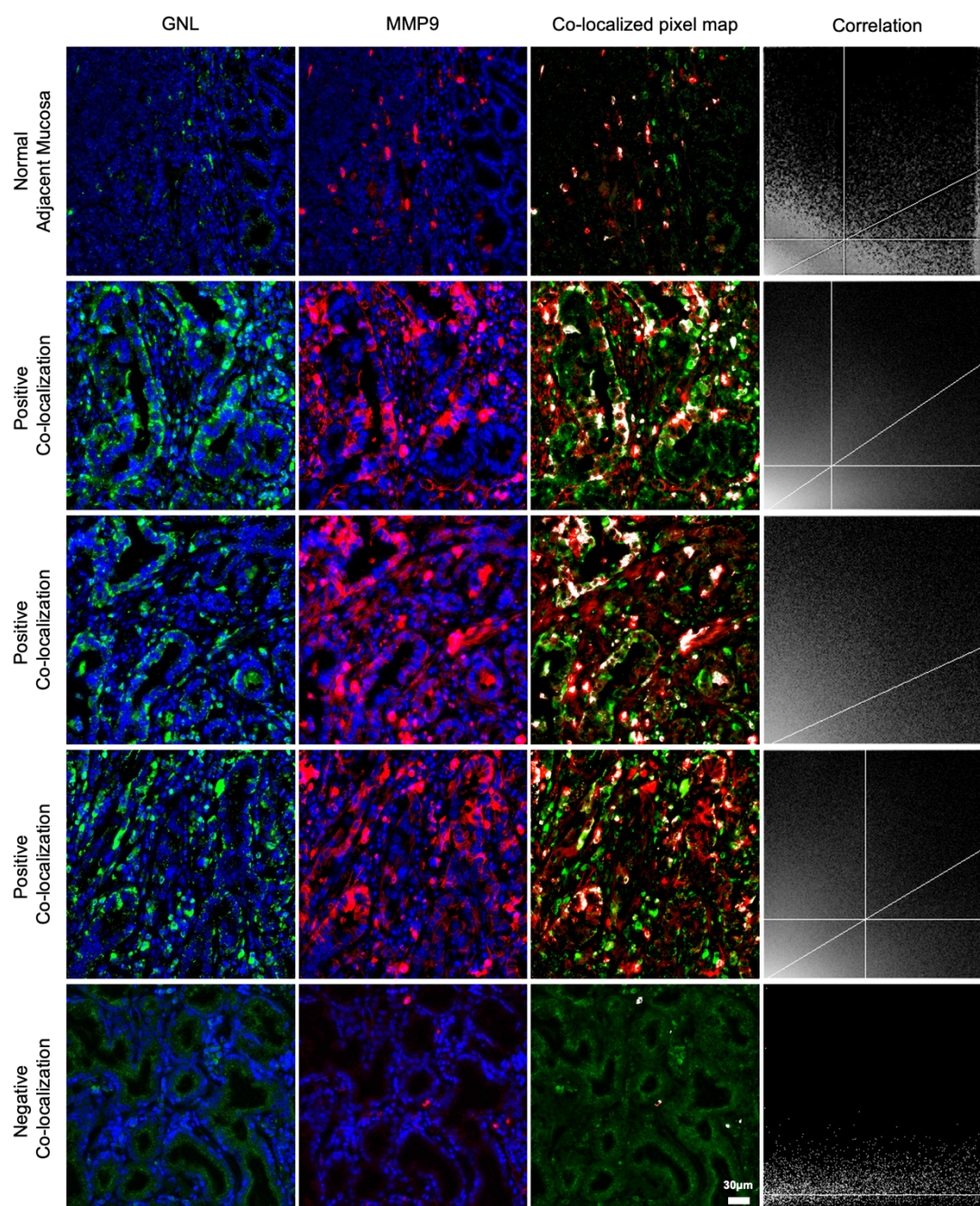


Figure S12. MMP9 and GNL staining is co-localized in GC tumors. Microscopic evaluation of FFPE GC tissues stained for DAPI (blue), MMP9 (red) and GNL (green) unveiled tumor areas with co-localization of MMP9 and GNL (grey/ white), supporting the existence of MMP9 carrying trimmed *N*-glycans ($n = 7$). This phenotype was not evident on normal adjacent mucosa (first row), neither in areas that are exclusively positive for one of the antigens (fifth row). Additionally, this phenotype appears to be restricted to tumor cells and, to a lesser extent, to tumor secretions. Our data highlight the cancer-associated nature of this glycoproteosignature. Images were acquired using a 40X objective and scale bar = 30 μm .

A co-localized pixel map and correlation curve (fourth column) were generated using the “Colocalization Threshold” test in Fiji software.

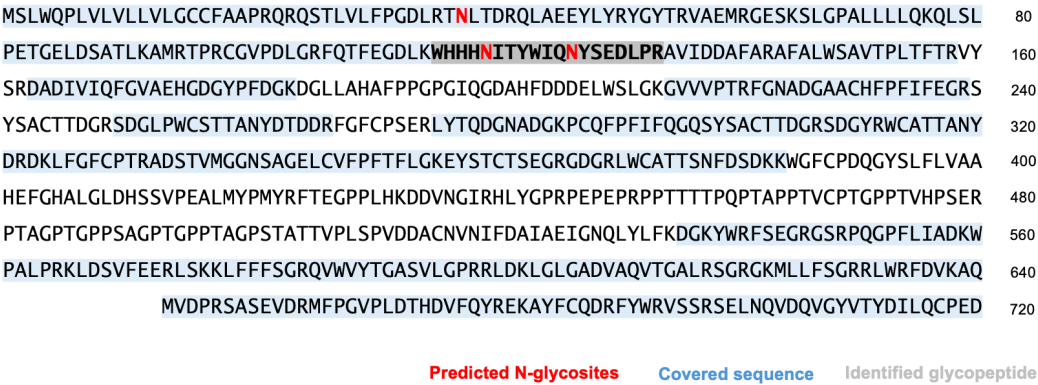


Figure S13. *N*-glycosite prediction unveiled three putative *N*-glycosylation sites on MMP9 protein sequence. According with NetNGlyc prediction, MMP9 presents three potential *N*-glycosites on Asn₃₈, Asn₁₂₀ and Asn₁₂₇ (red). Our MS data identified a glycopeptide carrying paucimannosidic *N*-glycans on two predicted *N*-glycosites (₁₁₆WHHHNITYWIQNYSEDLP₁₃₄; grey).

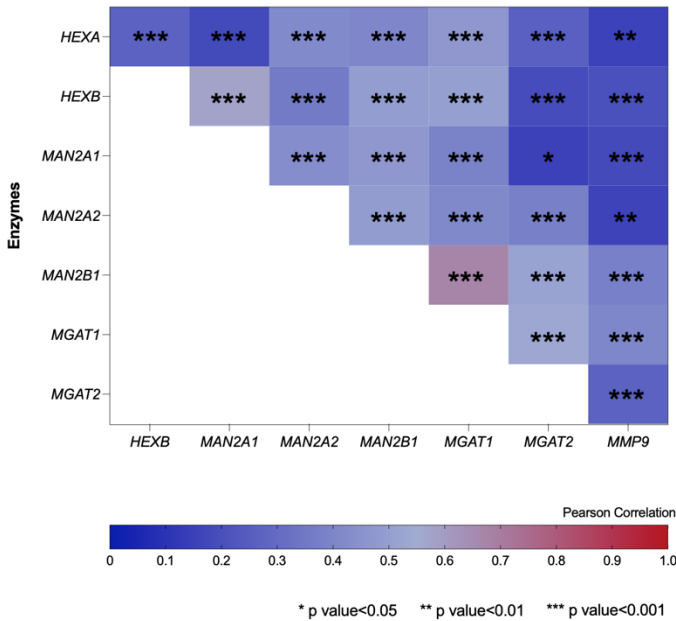


Figure S14. *MMP9* mRNA levels are positively correlated with relevant glycogenes involved in the main biosynthesis route of paucimannosidic *N*-glycans. *MMP9* is correlated in higher degree with *MAN2B1* ($R = 0.372$; $p < 0.001$) and *MGAT1* ($R = 0.401$; p

< 0.001), and in lower degree with *HEXA* ($R = 0.152$; $p = 0.002$), *HEXB* ($R = 0.199$; $p < 0.001$), *MANA21* ($R = 1.178$; $p < 0.001$) and *MAN2A2* ($R = 0.157$; $p = 0.001$) and *MGAT2* ($R = 0.264$; $p < 0.001$) ($n = 412$). Pearson's correlation method was used to assess the correlation levels between *MMP9*, hexosaminidases (*HEXA* and *HEXB*), mannosidases (*MAN2A1*, *MAN2A2* and *MAN2B1*) and glycosyltransferases (*MGAT1* and *MGAT2*). A p -value of 0.05 was set as minimal requirement for statistical significance.

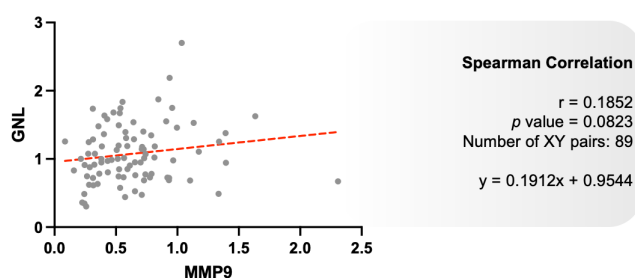
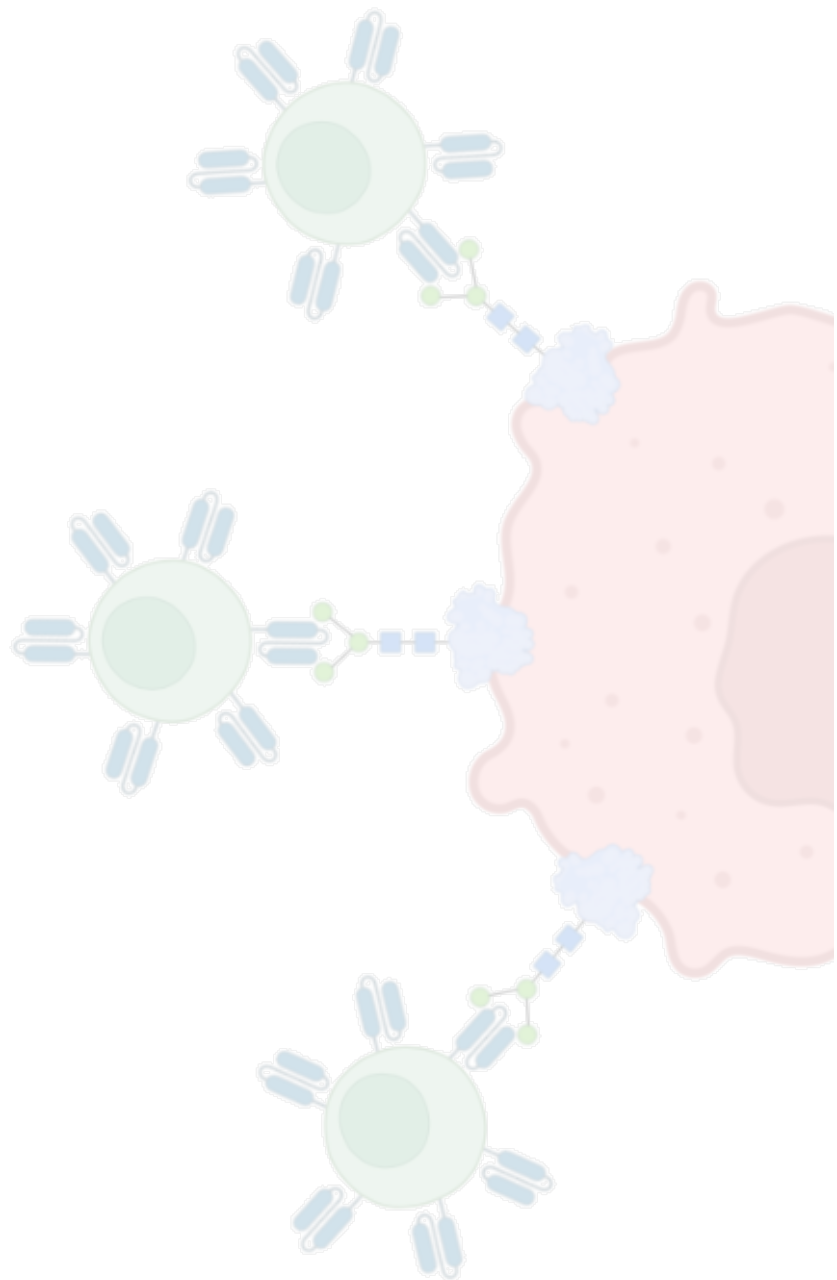


Figure S15. Serological levels of GNL do not correlate with MMP9 levels. Spearman correlation unveiled no significant correlation between serological GNL and MMP9 levels ($n = 89$; $p = 0.0823$; $R = 0.1852$). Statistical significance was considered when $p < 0.05$.



CONCLUDING REMARKS & FUTURE PERSPECTIVES

Concluding Remarks & Future Perspectives

GC is the fifth most common cancer worldwide and the fifth leading cause of cancer-related death (1). Although the incidence and mortality of GC are declining - partly due to improved *Helicobacter pylori* eradication and enhanced cancer screening (2) - it remains a highly aggressive and life-threatening malignancy. This reflects the limitations of a one-size-fits-all therapeutic approach (3). Therefore, there is an urgent need to establish novel targeted therapies for specific patient subgroups, particularly those with limited or no current treatment options (4). In this context, advanced-stage GC tumours exhibit profound dysregulation of glycosylation pathways, leading to distinct glycosignatures on the cell surface with significant potential for targeted therapy (5-9). Specifically, these tumours are characterized by hypersialylation, which promotes tumour invasion, immune evasion, and metastasis (10, 11). Moreover, complex *N*-glycans with increased branching and terminal sialic acids are associated with aggressive disease phenotypes. Other glycan features, such as core fucosylation and bisecting GlcNAc, have shown context-dependent roles and, in some cases, tumour-suppressive effects (12-15). More recently, a poorly explored class of *N*-glycans - paucimannosidic *N*-glycans - has emerged as a relevant group in pathological conditions (16). These truncated *N*-glycans result from altered activity of Golgi mannosidases and deficient elongation by *N*-acetylglucosaminyltransferases, which leads to incomplete glycan maturation (16-18).

This study investigates the expression of paucimannosidic *N*-glycans in GC from a tumour biology perspective, vowing for a more precise patient stratification and the development of novel immunotherapeutic strategies. Our findings reveal that advanced-stage GC tumours are enriched in paucimannosidic *N*-glycans, particularly $H_2N_2F_1$ and H_3N_2 , likely due to elevated expression of glycosidases such as HEXA, HEXB, and MAN2A1. Immunoassays demonstrated that GNL, which binds specifically to α -

mannose-rich structures like paucimannose, showed higher expression in advanced tumours, invasive fronts, and lymph node metastases. Furthermore, high GNL reactivity was associated with poor prognosis, particularly in intestinal-type GC, and outperformed traditional biomarkers (e.g., E-cadherin, p53, MSI, sTn, sLeA) in diagnostic accuracy analyses. GNL-based detection strategies may thus aid in identifying GC patients at high risk for aggressive disease. Additional glycoproteomic profiling enrichment using GNL confirmed the presence of trimmed *N*-glycans, especially on ribosomal proteins. Notably, MMP9 emerged as a cancer-specific glycoprotein carrying paucimannosidic *N*-glycans. Although total MMP9 expression alone did not predict prognosis, co-expression of MMP9 and GNL-reactive glycans (MMP9-GNL double-positive phenotype) was linked to advanced disease and lymph node metastasis, suggesting a role for glycan-mediated tumor progression and aggressiveness. In summary, our findings identify MMP9 carrying paucimannosidic *N*-glycans as a clinically relevant molecular phenotype associated with GC aggressiveness. While total MMP9 levels lack prognostic value on their own, the combined expression with GNL-reactive glycans provides important prognostic information, highlighting the value of post-translational modifications in enhancing biomarker utility. To our knowledge, this is the first report describing these truncated *N*-glycans in GC, offering novel insights for diagnostic/prognostic application and therapeutic targeting in this malignancy.

Future research should aim to dissect the impact of paucimannosylation on tumour progression, especially regarding immune modulation. Moreover, future studies should explore the molecular pathways linking glycosidase overexpression with glycan trimming and disease progression, offering novel therapeutic targets. Furthermore, future work should investigate how paucimannosylation of MMP9 influence its enzymatic function, stability, or interactions with the extracellular matrix, and assess the potential of MMP9 glycoforms as therapeutic targets in GC.

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