Supplementary Figure Legends:

Figure 1. CD133 mRNA expression, in the PB, increases with disease progression. CD133 relative expression was determined by RQ-PCR in PB samples of a lymphoma, before and after the therapeutic regimen. A 2.4-fold increase in CD133 relative expression was concomitant with disease progression in this lymphoma patient.

Figure 2. CD133+ and some KDR+ cells have the same staining and distribution pattern in tumour cryosections different lymphoma patients. Immunofluorescent staining of CD133 (A) and KDR (B) in consecutive LN sections of a representative lymphoma patient. KDR+ cells can be found on vascular cells or dispersed as single stained cells as CD133 expression. This staining pattern was observed in several (n=4) lymphoma patients. Amplification: 630x. Blue: DAPI (nuclei); Green: CD133/ KDR staining.

Figure 3. LN-EPC presence is not associated with lymphoma stage. A. Description of lymphoma stage (I-IV) according to lymphoma type (Indolent vs. Aggressive). The majority of the patients had high stage disease (stages III-IV), independently of lymphoma type. Lymphoma stage is determined according to organ involvement by malignant cells (stage IV being the higher). **B.** Percentage of LN-EPC positive biopsies according to lymphoma type and stage. As observed, LN-EPC were detected in low and high grade lymphomas with similar frequency.

Figure 4. CEPC and LN-EPC differ in CD133 mRNA isoform expression.

CD133 mRNA isoforms expression, determined by RT-PCR, in PB, BM and lymphoma biopsies from. RT-PCR analysis was performed with oligonucleotides specific of CD133-3' mRNA (exons 32-37). CD133-3A isoform is expressed in all samples; CD133-3C (without exon 35) is specific of circulating and bone marrow (BM) CD133

cells. This image is a representative result from all PB and tumour samples analyzed. PB: peripheral blood; BM: bone-marrow; K231: lymphoma cell line.

Table 1. Nucleotide sequences of the primers used in the RT-PCR and RQ-PCR reactions

Table 2. Lymphoma patient population characteristics. PB and LN biopsies were collected from 70 lymphoma patients. Described are the population characteristics according to median age, sex, lymphoma type and BM infiltration. The samples were collected prior to any treatment and none of the patients received any mobilization treatment at any stage that may have influenced EPC levels.

Table 3. CEPC levels correlate with response to treatment. CEPC were detected by RT-PCR and flow cytometry, during the clinical course (2 PB samples collected before (BT) and after treatment (AT)) of 11 lymphoma patients. The presence of CEPC was analyzed together with VEGF and SDF-1α systemic levels (ELISA) and with patients' clinical features (sex, therapeutic regimen, response to treatment, type of lymphoma). M: male; F: female; CR: complete response to treatment; PR: partial remission; R: rituximab; Ant: anthracyclins; Cis: cisplatinum; Chem: chemotherapy; Pred: prednisone; Ind: indolent; Agg: aggressive; NHL: non-Hodgkin lymphoma; +: increase after treatment; -: decrease after treatment; =: no differences after treatment, ND: not determined.

Table 4. CEPC and biopsy-EPC cells coexist in patients with lymphoma. EPC presence was detected by RT-PCR and flow cytometry in paired samples (PB and lymph node biopsies) of 10 lymphoma patients to determine if CEPC and LN-EPC could coexist in the same individual. Represented are the frequencies of detecting each, both or none of the EPC populations in a group of 10 patients with lymphoma. LN-EPC: biopsy-EPC; CEPC: circulating EPC.

Table 5. List of genes upregulated on LN-EPC (LCB represents the variation of gene expression comparing LN-EPC with CEPC) (Excel File).