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1 A new prognostic index for overall survival in malignant pleural mesothelioma: the

2 rPHS (regimen, PS, Histology, or Stage) index

3

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23

24   Running head:

25   A prognostic index in malignant mesothelioma

26

27

28   **ABSTRACT**

29   **Background**

30   Existing prognostic indices (PI) for malignant pleural mesothelioma (MPM) do not

31   incorporate the recent advances in oncology care. The purpose of this study was to

32   provide a PI for overall survival (OS) in MPM patients treated with chemotherapy with

33   pemetrexed (PEM) or best supportive care (BSC) in the recent clinical setting.

34   **Methods**

35   A retrospective cohort study was performed in two hospitals in Japan (2007 - 2013).

36   The primary outcomes were OS. The Cox proportional hazards model was used for

37   multivariable analyses to identify prognostic factors. A final model was chosen based on

38   both clinical and statistical significance.

39   **Results**

40   A total of 283 patients (CTx: n=228, BSC: n=55) were enrolled in the study. On

41   multivariate analysis, regimen including platinum plus PEM, a performance status > 0,

42   non-epithelial histological type, and stage IV disease predicted poor OS in CTx patients.

43   As hazard ratios of individual risk factors were approximately similar, a prognostic

44   index for OS was constructed by counting the risk factors. Median OS in CTx patients

45   decreased by each 1-point increase in this count: 1030 days for zero; 658 days for one;

46   373 days for two; 327 days for three; 125 days for four. Internal validation using the

47   bootstrapping technique showed robustness of the model (c-index, 0.677; 95%

48   Confidence Interval [CI], 0.624-0.729). Further, the discrimination was consistent in

49   BSC patients (c-index, 0.799; 95% CI, 0.725-0.874).

50   **Conclusions**

51   This novel index can provide clinicians and MPM patients with a better framework for

52   discussing prognosis at the time of diagnosis.

53

54   **A mini-abstract:**

55   We developed a new prognostic index for malignant pleural mesothelioma. The index

56   reflects the recent real-world data. The index showed better discrimination than

57   previous index.

58

59   *Keywords:*

60   *Malignant pleural mesothelioma – pemetrexed - best supportive care - prognostic index*

61   *- palliative care.*

62

INTRODUCTION

Malignant pleural mesothelioma (MPM) used to be a rare malignancy of the

mesothelium. In recent years, the incidence of this disease has increased, and this trend

will likely continue worldwide over the next decade (1).

Despite recent advancements in treatment, surgery, radiotherapy and chemotherapy or

multimodality therapy has not be proven to be curative (2–4) . For the majority of

patients, treatment options are limited to palliative chemotherapy and best supportive

care (BSC)　(5).

In oncologic palliative care, early determinations of prognosis play an important role in

guiding end-of-life care and efforts designed to improve patients' quality of life (6, 7).

To determine the prognosis of patients with MPM, four prognostic indices (PI) have

been developed; one by the Cancer and Leukaemia Group B (CALGB) (8), and three by

the European Organization for Research and Treatment of Cancer (EORTC) (9–11).

While the first two PIs from EORTC can indicate either a favorable or an unfavorable

outcome, neither can predict the duration of survival, which means both are impractical

when discussing life expectancy with a patient. The CALGB PI is complex to use,

because it has various cutoffs to consider. Above all, these PIs are based on clinical trial

data and may not be applicable to the clinical setting. Further, they do not incorporate

81   information regarding pemetrexed, which can improve overall survival (OS), and does

82   not incorporate recent advancements in supportive care (3, 12–14). Therefore, while

83   existing PIs might be useful for researchers in deciding which patients to include in

84   clinical trials, these systems are less useful for clinicians who need to discuss prognoses

85   with their MPM patients.

86   The purpose of this study was to provide a new PI for OS in MPM patients who

87   underwent treatment with pemetrexed or best supportive care in a recent clinical setting.

88

89   **Materials and methods**

90   **Study design and patients**

91   A retrospective cohort study was performed, covering the period between April 1st, 2007

92   and March 31st, 2013. The cohort was defined as all patients with histologically proven

93   (15) MPM at either one of two tertiary hospitals that serve the South Hanshin medical

94   region, which is an area of high MPM incidence area in Japan (16).

95   Patients who had more than one cancer, underwent autopsy, or who received palliative

96   chemotherapy without pemetrexed were excluded, Because our purpose is to develop a

97   new PI in MPM patients who underwent treatment with pemetrexed which is the

98   "standard of care" (5). Patients who had received chemotherapy or radiotherapy before

99   diagnosis, trimodal therapy, or surgical therapy extra-pleural pneumonectomy or

100   pleurectomy or decortication) were excluded to avoid confounding influences (17).

101

102   **Definitions of prognostic variables**

103   Potential prognostic factors that were analyzed included: histological subtypes (15),

104   International Mesothelioma Interest Group stage (18), chemotherapy regimen, age,

105   gender, Eastern Cooperative Oncology Group performance status (PS) (19), subjective

106   symptoms, smoking history, asbestos exposure history, comorbidities (Charlson score

107   (20)) and baseline blood or effusion parameters at the time of diagnosis.

108

109   **Primary outcomes measurement**

110   The primary outcome endpoint was OS, as defined by the length of time from the date

111   of diagnosis to death. Patients who had not died or who were lost to follow-up were

112   censored when they were last known to be alive before September 1st, 2013.

113

114   **Statistical analyses**

115　We developed the PI in those who were treated with chemotherapy to minimize the bias

116　due to confounding by indication (21). We also evaluated the applicability of the PI in

117　those that received BSC.

118　In derivation, step continuous and nominal prognostic variables were dichotomized

119　according to previous studies (8, 9, 11, 21–27). OS was estimated using the

120　Kaplan–Meier method. The log-rank tests for each prognostic factor were used for

121　univariate analyses. The Cox proportional hazards model was used for multivariate

122　analyses. The Akaike's information criterion (AIC), Schwartz's Bayesian information

123　criterion (BIC), and Harrell's c index (c-index) were used for the discrimination of the

124　model. A final model was chosen based on both clinical and statistical significance. We

125　compared the discrimination of our index with the EORTC prognostic index (9) and the

126　progression-free index of EORTC (11).

127　Calibration curves showing agreement between observed and predicted outcomes over a

128　range of predicted probabilities were drawn. We also drew Cox-Snell residuals and

129　measured Moreau, O'Quigley, and Lellouch statistics (28). We drew log-log hazards

130　curves and tested the proportional hazard assumption. The bootstrapping technique was

131　used for the internal validation (for 500 replications (29)).

132   We carried out sensitivity analysis using multiple imputation for variants with clinically

133   significance. Two-sided p values < 0.05 were considered to indicate statistical

134   significance. We used Stata® ver. 13.0 (Stata Corp., College Station, TX).

135

136   **Ethical considerations**

137   This study was performed according to the Declaration of Helsinki and the Ethical

138   Guidelines for Epidemiological Research by the Japanese Ministry of Health, Labour

139   and Welfare. The protocol for the study was approved by the Ethics Committee of

140   Kyoto University Graduate School and Faculty of Medicine (E1883). The protocol was

141   registered in the University Hospital Medical Information Network Clinical Trials

142   Registry with the number: UMIN000011733.

143

144   **Results**

145   This study included 228 patients who were treated with chemotherapy with pemetrexed

146   and 55 patients who received BSC (Figure 1). Patient characteristics are shown in Table

147   1. Survival curves for each group are shown in the Figure 2.

148   The median lengths of follow-up were 345.5 days for the chemotherapy group and 250

149   days for the BSC group. During the follow-up period, 161 patients (70.6%) died in

150   chemotherapy group, and 40 patients (72.7%) died in the BSC group, respectively.

151   Univariate survival analyses are also shown in Table 1. Fifteen parameters were

152   significantly correlated with OS according to univariate analyses: asbestos exposure, PS,

153   dyspnea, anorexia, chest pain, body weight (BW) loss, fever, histological type, Stage,

154   Regimen, white blood cell (WBC), platelet (Plt) count, C-reactive protein (CRP),

155   Lactate dehydrogenase (LDH), and cytokeratin-19 fragment (CYFRA).

156   Because of the theoretical collinearity of symptom variables, we chose only PS with

157   respect to clinical relevance. We repeated the multivariate analysis while analyzing

158   WBC, Plt, and CRP, separately, because of the collinearity of inflammatory variables.

159   The discrimination for PS, Asbestos Exposure, Histology, Stage, Regimen, LDH, and

160   CYFRA were 823 (AIC), 844 (BIC), and 0.714 (c-index). The discrimination for seven

161   variables with WBC were 821 (AIC), 845 (BIC), and 0.726 (c-index). The

162   discrimination for six variables with CRP were 825 (AIC), 849 (BIC), and 0.715

163   (c-index). The discrimination for six variables with Plt were 824 (AIC), 848 (BIC), and

164   0.711 (c-index). We entered WBC into a stepwise backward Cox proportional hazards

165   model (Table 2). PS, histology, stage, and regimen remained significant after the

166   multivariate analysis. Hazard ratios of individual risk factors were 1.82-2.25. Therefore,

167   a PI for the OS was constructed using a simple count of the number of risk factors

168   (Table 3). The median OS of each category is shown in Table 4.

169   We calculated the discrimination of the rPHS (regimen, PS, Histology, or Stage) index.

170   The c-index was 0.677. After 500 bootstrap replications from the original patients, the

171   95% confidence interval (CI) of the c-index of the PHS score was 0.624-0.729.

172   We calculated the c-index for the EORTC prognostic index (9), which was 0.569. The

173   difference between the two indices persisted after bootstrap replications (0.108; 95%CI,

174   0.053-0.163). We also calculated the c-index for the progression-free index of the

175   EORTC (11), which was 0.552. The difference between the two indices persisted after

176   bootstrap replications (0.125, 95%CI, 0.082-0.166).

177   There was good calibration of the model, with close agreement between observed and

178   predicted OS (Figure S1), and also with close agreement between Cox-Snell residuals

179   and the 45-degree slope (Figure S2). The Moreau, O'Quigley, and Lellouch test showed

180   that the model fit of the Cox regression model was adequate ($p = 0.38$).

181   We drew log-log hazards curves for the CTx group which were parallel (Figure S3). The

182   p value of the test for the proportional hazard assumption was 0.07.

183   We carried out sensitivity analysis using multiple imputation to create and analyze 10

184   multiply imputed datasets. We imputed only PS with regards to clinical significance.

185   These estimates and their standard errors were combined using Rubin's rules (30). The

186   results showed consistency (Table 4). The discrimination was also consistent in the BSC

187   group (c-index, 0.799; 95%CI, 0.725-0.874).

188

189   **Discussion**

190   We developed a new PI for patients with MPM that predicts median OS, incorporates

191   pemetrexed information, and incorporates recent advancements in supportive care in the

192   normal clinical setting. The rPHS index is obtained by a simple count of the risk factors

193   (regimen including platinum plus PEM, PS>0, non-epithelial histology, and stage>3).

194   The index can stratify patients into four different prognostic groups with different

195   median survivals. The index has good discrimination for those treated with pemetrexed

196   group as well as those treated with BSC.

197   Patients with advanced cancer often want to know their prognosis (31). One study (32)

198   reported that patients with advanced cancer have an overwhelming preference for an

199   opportunity to prepare for the end of life. They want to know that their families are

200   prepared for their death, which often includes having finances in order, and for patients,

201 having funeral arrangements planned. They want to have the opportunity to resolve

202 unfinished business, remember personal accomplishments, and to say goodbye to

203 important people. In order to allow these patients to direct their energies to these matters,

204 it is important to provide them with accurate information regarding their prognosis. In

205 fact, early palliative care, including early accurate perceptions of prognosis, has

206 improved the quality of life and possibly the OS of patients with advanced cancer (6).

207 We believe that the present findings will influence the usual care of MPM patients for

208 several reasons. When one patient diagnosed with MPM and decided to treat with

209 pemetrexed-regimen, the patient and their physician can discuss based on the

210 median OS of the rPHS index. Without the index we discussed the prognosis based

211 on the median survival time from the trial or the cohort study. Our PI consists of

212 variables frequently used in usual care of MPM patients. Indeed, PS, histology, and

213 stage are well-known prognostic factors in previous studies (8–11, 33) and are

214 components of the evaluation at the time of initial diagnosis (34). Further, our PI can be

215 calculated easily by simple counting; calculators are not necessary, and our PI has more

216 discriminatory power than the EORTC PI (9), which is one of the best-known clinical

217 PIs. We note that the distribution of median age and OS were different when comparing

218 previous reports (8–11) and our CTx cohort; our study included more elderly patients

219 (67.7 versus 58-62 years), and our study included patients with relatively better

220 prognoses (11.5 versus 5-12.6 months). The cohort of our study ensures the

221 generalizability of the findings, because the two hospitals cover the South Hanshin

222 medical region and any patients with MPM in this region will visit one of these two

223 hospitals. So, the participants in the present study are a good representation of patients

224 with MPM. We included only patients with histologically proven MPM and not those

225 with only cytologically proven MPM. Because there is morphologic overlap between

226 benign reactive mesothelial cells and malignant cells of mesothelioma (15), it is not

227 recommended to make a diagnosis of mesothelioma based on cytology alone (34). We

228 think that this restriction ensured our study result.

229 Our cohort consisted of patients treated with BSC. For the small number of BSC

230 participants we didn't develop another index for BSC patients, but validated PHS index.

231 The discrimination was good (c-index, 0.799; 95% CI, 0.725-0.874). No previous study

232 has validated a PI in patients treated with BSC. This information will be useful for

233 discussions regarding prognosis between clinicians and their patients.

234 Since 1998, several PIs have been described. In contrast to our PHS index, other PIs

235 were based on clinical trial data. Therefore, in the context of usual care, our PHS index

236 might be more widely applicable than other PIs. We cannot compare our PI with the PI

237   of Bottomley (23) because we did not evaluate patients with the EORTC LC13 or

238   QLQ-C30. Their PI's c-index was 0.66. The point estimation was similar to that of our

239   PI. Pass (27) reported stage, histology, sex, age, treatment, adjuvant treatment, platelets

240   and WBC are clinical prognostic factor except for PS. We think this discrepancy may

241   reflect the difference of target population. We excluded those received surgery, but

242   Pass's target population is those received either palliative or potentially curative surgery.

243   There are several limitations in the study. First, this was a retrospective study with a

244   substantial number of missing PS data, so we performed sensitivity analysis using

245   multiple imputation. The result confirms the robustness of our model. Second, we were

246   not able to know the reason why each patient treated with the modality because this is a

247   retrospective study and treatment allocations were not protocol based. To clarify the

248   preferences for treatment in MPM patients prospective qualitative and quantitative

249   studies will be needed (36). But this limitation reflects the normal clinical setting. Third,

250   we assessed internal validation with the bootstrap method, but the sample size of this

251   study did not allow for external validation, so validation studies are needed.

252   We developed a new PI using PS, histology, and stage for MPM patients treated with

253   chemotherapy or BSC. This PI will allow better discussion between clinicians and

254   patients with regards to prognosis. Further prospective studies using this PI are

255   warranted.

256

261

262   **Conflict of interest statement**

263   None declared.

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371

372

Table 1 Patient characteristics and results of univariate analyses of OS

Clinical factors	Chemotherapy (n = 228), N (%)	Median OS (days)	95%CI	p value	BSC (n=55), n (%)
Age (years) mean±SD	67.7±8.2				74.5±9.6
Age (years)					
75>	181 (79.4)	512	375-562	0.2000	24 (43.6)
75≤	47 (20.6)	366	190-441		31 (56.4)
Gender					
Female	39 (17.1)	514	314-699	0.4700	13 (23.6)
Male	189 (82.9)	432	359-524		42 (76.4)
Smoke					
Never	65 (30.0)	524	366-624	0.4100	19 (38.0)
Current / Ever	152 (70.0)	425	327-524		31 (62.0)
Missing	11				5
Charlson comorbidity index					
<2	205 (89.9)	461	372-533	0.5100	42 (76.4)
2≤	23 (10.1)	366	224-1213		13 (23.6)
Asbestos exposure					
No	28 (12.4)	710	327-1213	0.0480	
Yes	197 (87.6)	397	353-511		14 (26.4)
Missing	3				39 (73.6)
PS					2
0	37 (22.4)	926	524-1372	0.0014	
1≤	128 (77.6)	434	362-562		19 (41.3)
Missing	63				37 (58.7)
Dyspnea					9
No	52 (33.8)	658	524-1030	0.0003	13 (31.7)
Yes	102 (66.2)	425	319-512		28 (68.3)
Missing	74				14
Anorexia					
No	145 (82.4)	524	432-654	0.0001	29 (55.8)

Yes	31 (17.6)	296	166-373		23 (44.2)
Missing	52				3
Chest pain					
No	58 (39.2)	648	511-926	0.0007	16 (43.2)
Yes	90 (60.8)	353	263-432		21 (56.8)
Missing	80				18
BW loss					
No	96 (70.7)	566	512-804	0.0001	20 (60.6)
Yes	41 (30.0)	299	177-425		13 (39.4)
Missing	91				22
Fever					
No	92 (76.7)	524	397-648	0.0280	38 (92.7)
Yes	28 (23.3)	353	223-518		3 (7.3)
Missing	108				14
Histological type					
Epithelial	149 (65.4)	545	493-640	0.0000	17 (30.9)
Non-epithelial	79 (34.7)	277	221-330		38 (69.1)
Stage					
I-III	133 (58.3)	549	461-658	0.0000	30 (54.5)
IV	95 (41.7)	327	242-375		25 (45.5)
Regimen					
Platinum plus PEM	205 (89.9)	221	373-547	0.0007	
PEM monotherapy	23 (10.1)	499	86-425		
WBC (/μl)					
8300>	160 (70.5)	512	391-598	0.0400	36 (65.5)
8300≤	67 (29.5)	359	238-501		19 (34.5)
Missing	1				
Neutro/lymph					
5>	182 (82.4)	445	368-549	0.0600	35 (64.8)
5≤	39 (17.7)	362	188-514		19 (35.2)
Missing	7				1
Hb (g/dL)					
10≤	218 (96)	445	372-544	0.0700	45 (81.8)
10>	9 (4.0)	224	66-526		10 (18.2)
Missing	1				

Plt (10^5/µl)					
40>	188 (82.8)	461	373-549	0.0100	42 (76.4)
40≤	39 (17.2)	327	176-526		13 (23.6)
Missing	1				
ALP (IU/l)					
Abnormal	32 (14.9)	397	228-562	0.93	0 (0.0)
Normal	183 (85.1)	441	362-544		53 (100.0)
Missing	13				2
LDH (IU/L)					
Abnormal	26 (11.6)	493	375-544	0.011	11 (20.4)
Normal	198 (88.4)	242	87-603		43 (79.6)
Missing	4				1
CRP (mg/dl)					
5>	189 (83.3)	461	373-549	0.0076	40 (72.7)
5≤	38 (16.7)	359	167-518		15 (27.3)
Missing	1				
CEA (ng/ml)					
5>	200 (94.3)	338	156-NE	0.7800	45 (95.7)
5≤	12 (5.7)	441	366-526		2 (4.3)
Missing	16				8
CYFRA (ng/ml)					
3.5>	162 (75)	512	375-598	0.0090	22 (48.9)
3.5≤	54 (25)	368	242-445		23 (51.1)
Missing	12				10
Pleural glucose (mg/dl)					
40>	21(22.3)	511	156-710	0.2200	10 (30.3)
40≤	73(77.7)	373	319-547		23 (69.7)
Missing	134				22

Abbreviations: N, number; OS, overall survival; SD, standard deviation; CI, confidence interval; BSC, best supprotive care; PS, Eastern Cooperative Oncology Group performance status; BW, body weight; PEM, pemetrexed; WBC, white blood cell; Neutro, neutrocyte; Lymph, lymphocyte; Hb, hemoglobin; Plt, platelet; ALP, alkaly phosphatase; LDH, lactate dehydrogenase; CRP, C-reactive protein; CEA, carcinoembryonic antigen; CYFRA, cytokeratin-19 fragment.

Table 2 Backward Cox proportional hazards model

Clinical factors	HR	95%CI
PS		
0	1	
1≤	2.40	1.36-4.23
Asbestos exposure		
no	1	
yes	1.64	0.75-3.58
Histological type		
Epithelial	1	
Non-epithelial	2.16	1.40-3.32
Regimen		
Platinum doublet	1	
Pemetrexed only	3.18	1.59-6.39
Stage		
I-III	1	
IV	1.57	1.03-2.39
LDH		
Normal	1	
Abnormal	1.46	0.71-2.99
CYFRA (ng/ml)		
3.5>	1	
3.5≤	1.10	0.69-1.76
WBC (/µl)		
8300>	1	
8300≤	1.56	0.99-2.45

Abbreviations: HR, hazard ratio; CI, confidence interval; PS, Eastern Cooperative Oncology Group performance status; LDH, lactate dehydrogenase; CYFRA, cytokeratin-19 fragment; WBC, white blood cell.

Table 3 Final model

Clinical factors	HR	95% CI	Score
PS			
0	1		1
1≤	2.06	1.22-3.44	
Histological type			
Epithelial	1		1
Non-epithelial	2.15	1.41-3.26	
Stage			
I-III	1		1
IV	1.82	1.23-2.69	
Regimen			
Platinum plus PEM	1		1
PEM monotherapy	2.25	1.16-4.36	

Abbreviations: HR, hazard ratio; CI, confidence interval; PS, Eastern

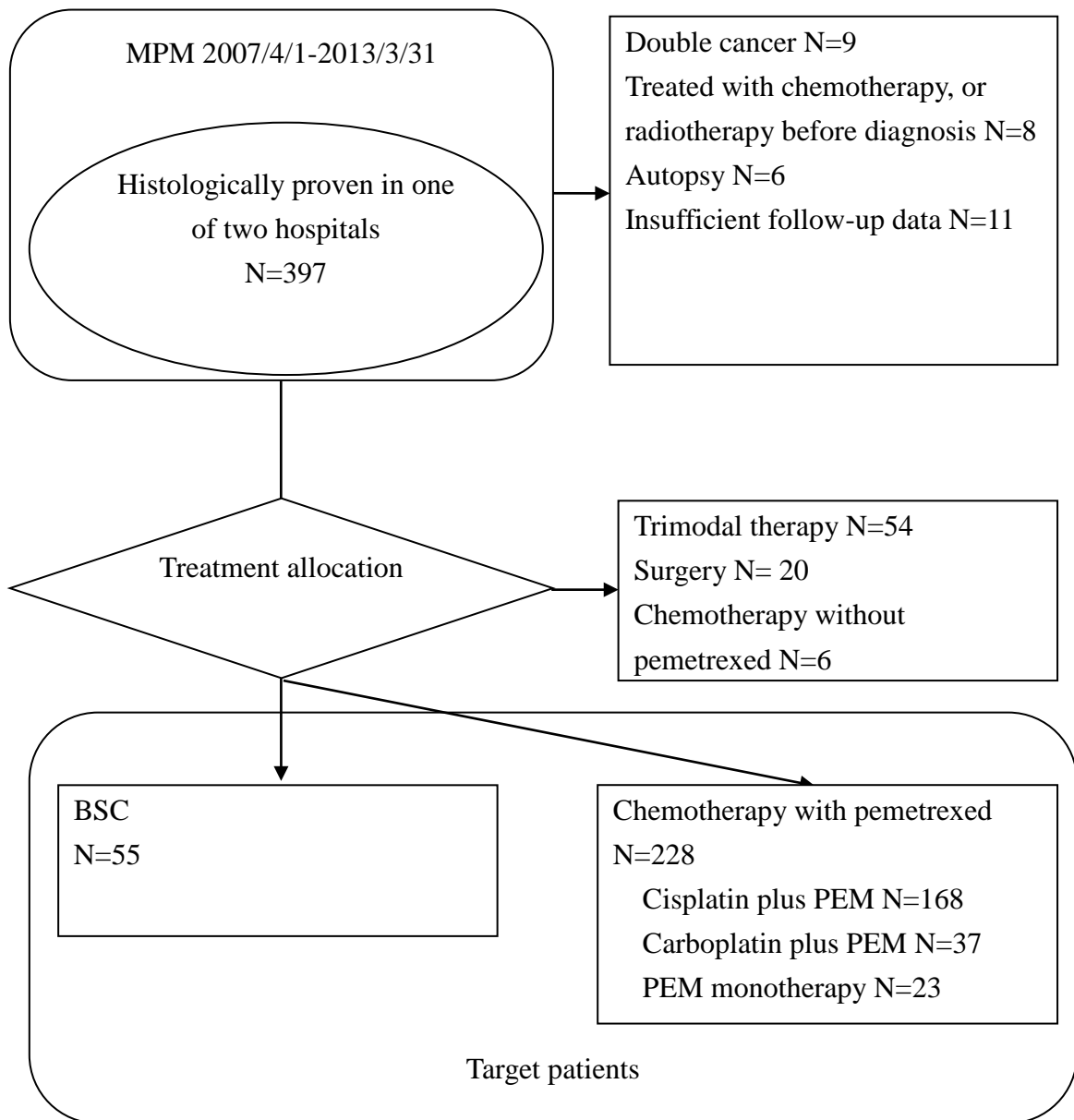Cooperative Oncology Group performance status; PEM, pemetrexed.

Table 4 The rPHS index for overall survival (sensitivity analysis)

	Chemotherapy			**Best supportive care**		
Score	**N**	**Median OS (days)**	**95% CI**	**N**	**Median OS (days)**	**95%CI**
0	24 (28)	1030 (926)	661-1399(598-1253)			
1	57 (76)	658 (603)	444-872 (458-678)	6 (7)	573 (573)	530-616 (477-669)
2	56 (79)	373 (367)	223-522 (305-429)	15 (20)	408 (402)	178-638 (221-583)
3	22 (39)	327 (240)	189-465 (133-347)	11 (20)	250 (94)	11-489 (0-228)
4	5(6)	125(48)	16-234(0-184)	6 (8)	26 (34)	0-103 (0-126)

rPHS index = (if platinum + PEM 0, otherwise 1) + (if PS 0<, otherwise 0) + (if Histology non-epithelial, otherwise 0) + (if Stage=4, otherwise 0)

Abbreviations: N, number; OS, overall survival; CI, confidence interval; NE, not estimable; PS, Eastern Cooperative Oncology Group performance status; PEM, pemetrexed.

Figure 1 Patient flow diagram


```
┌─────────────────────────────┐        ┌──────────────────────────────────┐
│   MPM 2007/4/1-2013/3/31     │        │ Double cancer N=9                │
│                             │        │ Treated with chemotherapy, or    │
│   ╭───────────────────╮     │   →    │ radiotherapy before diagnosis N=8│
│   │ Histologically proven │   │        │ Autopsy N=6                      │
│   │   in one of two       │   │        │ Insufficient follow-up data N=11 │
│   │   hospitals N=397     │   │        │                                  │
│   ╰───────────────────╯     │        └──────────────────────────────────┘
└─────────────────────────────┘
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MPM 2007/4/1-2013/3/31

Histologically proven in one of two hospitals
N=397

Double cancer N=9
Treated with chemotherapy, or radiotherapy before diagnosis N=8
Autopsy N=6
Insufficient follow-up data N=11

Treatment allocation

Trimodal therapy N=54
Surgery N= 20
Chemotherapy without pemetrexed N=6

BSC
N=55

Chemotherapy with pemetrexed
N=228
  Cisplatin plus PEM N=168
  Carboplatin plus PEM N=37
  PEM monotherapy N=23
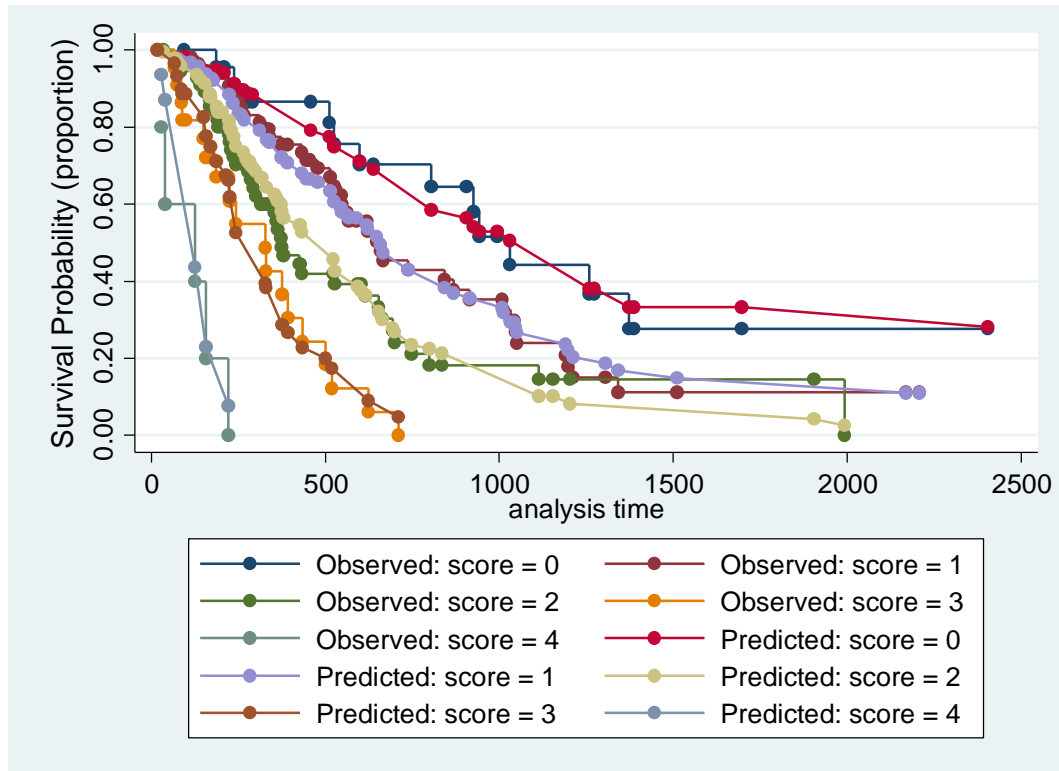
Target patients

Abbreviations: N, number; MPM, malignant pleural mesothelioma; BSC, best

supportive care.

Figure 2 Survival curve (days)
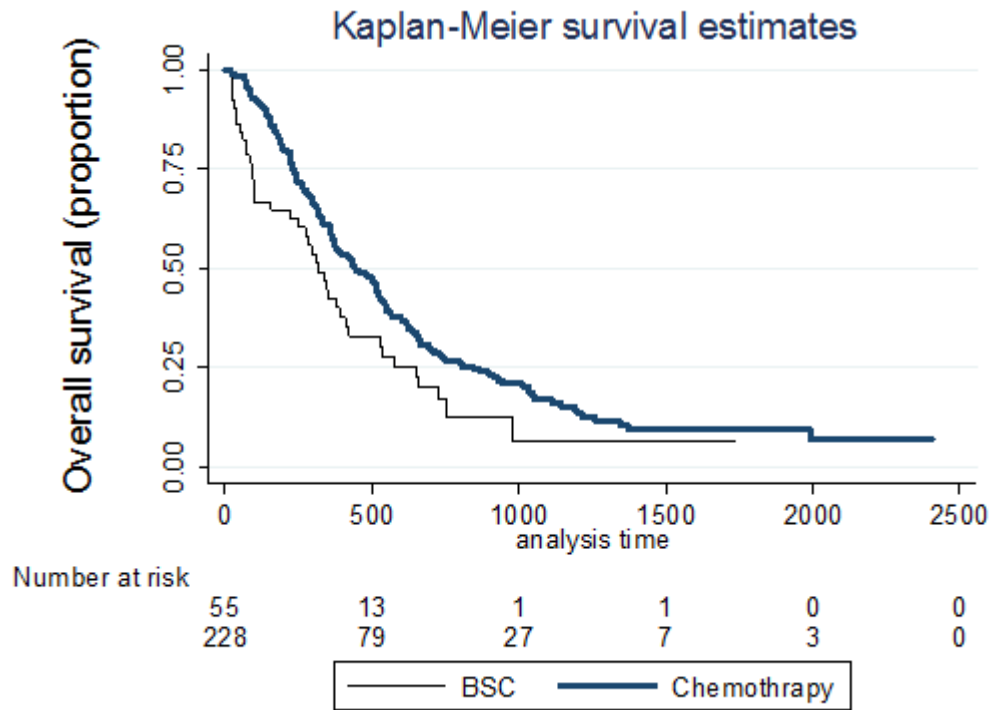
Abbreviations: BSC, best supportive care;

Figure S1 Calibration Kaplan-Meire curve of the rPHS index for chemotherapy group

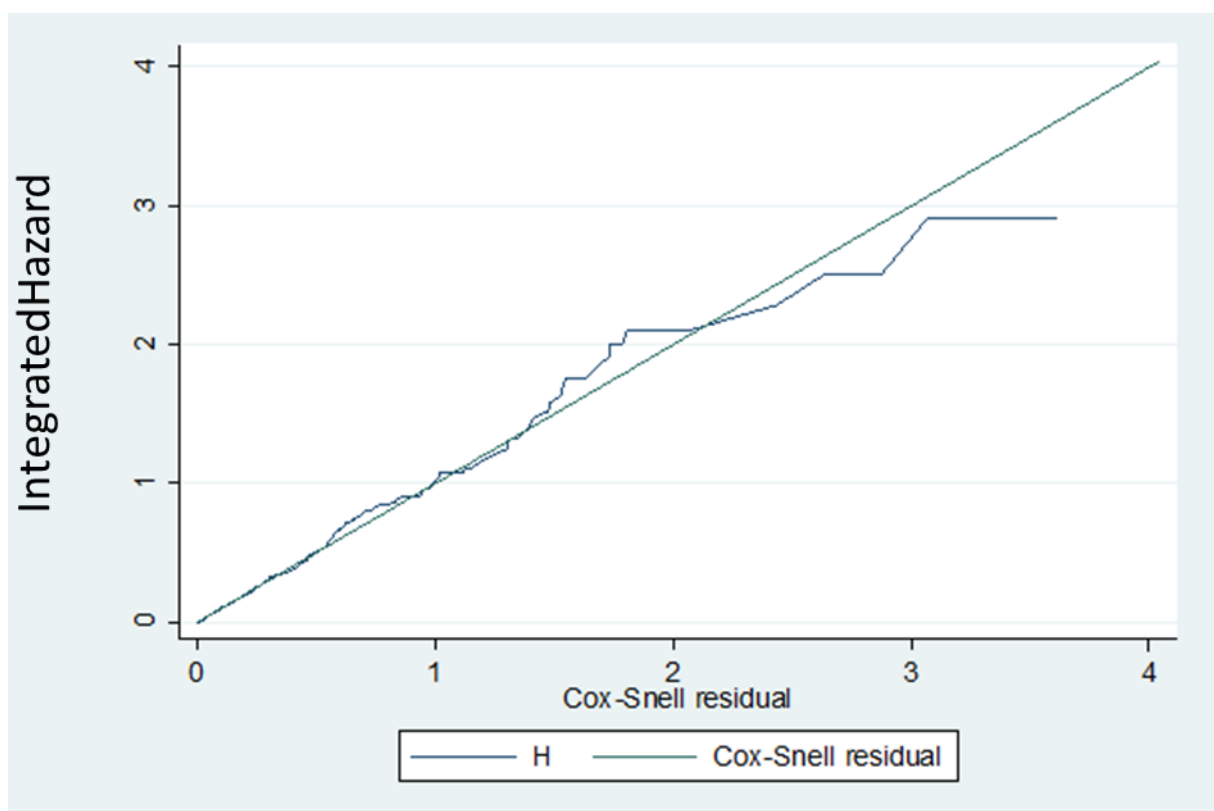Abbreviations: BSC, best supportive care;

Figure S2 Cox-Snell Residuals Graph

Figure S3 Cumulative hazards curves for the pemetrexed (CTx) group