



## Statistical Analysis Reports of Phase III Trials

ST-006-WIN-03

Version: 2

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# 1 PURPOSE

To describe the contents of the non inferential parts of statistical analysis reports (interim analysis reports or final analysis reports) for phase III clinical trials.

# 2 INSTRUCTION

## 2.1 Before starting the analysis report

Make sure that the study analysis plan is absolutely clear in respect of the following points:

- ◆ How endpoints are calculated (For time to event endpoints, this includes specification of the starting date, end date, what events are considered to be part of the endpoint, and what constitutes censoring and/or competing risks);
- ◆ Define the analysis populations;
- ◆ For the primary analysis of each endpoint, the analysis population to be used, whether it is a test of superiority or non inferiority, the statistical test to be used (for example Cox or Logrank), whether it is one sided or two sided, the significance level to be used, and whether or not it is adjusted or stratified for factors used at the time of the randomization (or for other prognostic factors);
- ◆ In case of central review of pathology or response, specify how these data will be taken into account in the analysis;

If not sufficiently detailed in protocol and/or Statistical Analysis Plan (SAP), please refer to ST-005-SOP.

## 2.2 Standard table of contents of Analysis Reports

The analysis report is to be structured according to the form ST-006-AF-05.

	Chapter	Interim Analysis Report	Final Analysis Report
1	Summary of the trial (from Trial Status Report (TSR))	X	X
2	Statistical considerations and study history (includes summary of major amendments affecting the statistics and of past interim analyses, if any)	X	X
3	Objectives of the present analysis and data selection for this report (includes statement about cut-off data and database lock date, total number of events achieved vs planned)	X	X
4	Patient availability (recruitment, follow-up, eligibility, patient populations used in the analysis)	X	X
5	Baseline characteristics	X	X
6	Compliance to protocol	X	X

7	Exposure to treatment	X	X
8	Safety evaluations	X	X
9	Reasons for stopping treatment	X	X
10	Post-treatment evaluations ( <i>as appropriate: response to treatment, surgery and pathology ...</i> )	X	X
11	Disease status ( <i>includes tables of frequency of events, sequence of events</i> )	X	X
12	Statistical inference on efficacy endpoints ( <i>clearly identify which analyses are primary/secondary/exploratory</i> )	X (if efficacy interim only)	X
13	Compliance to Quality of Life (if endpoint of the study)		X (only for final report of efficacy)
14	Summary of the results	X	X
15	CONSORT flow chart		X
16	Short Study Report to Authorities <b>This section is required only for the final analysis of trials that triggers the "end of the study" defined in the protocol and must be presented in a separate document</b>		X (only if end of study)

Supplementary chapters or sections within chapters may be added as necessary.

## 2.3 Patient selection

All patients are accounted for in the reports except those who never signed an informed consent or who withdrew consent and asked that none of their data be used. Such patients, if any have been identified, are reported separately in the publication and in all reports: the total number of such patients and the fact that they are excluded is mentioned at the beginning of the report, no other data is reported.

It may occur that some centers were "quality excluded" due to poor data documentation, Such patients are reported in the recruitment figures but their exclusion from analysis is documented in the chapter "data selection for the present analysis".

**The patient population (subset) used must be clearly stated at the beginning of each chapter.**

### 2.3.1 General guidelines for data display

- ◆ Frequency tables are tabulated for all categorical variables, by level of the variable.
- ◆ Whenever categories prompt for a specification, a listing details for the patients fulfilling the condition the patient id, institution, (eligibility) treatment, value of the item and text field contents.

- ◆ Time delays are calculated as delays in days between the past event and the date of entry (date of entry – date of past event + 1), and expressed in a suitable time unit. They are presented using median and range, and/or categorized into appropriate intervals.
- ◆ Continuous variables such as laboratory data, for which a grading system exists and is specified in the protocol are recoded into the corresponding categories. Whenever no specific grading exists, lab data are categorized in function of the normal range as below the lower normal limit, within the normal range, above the upper normal limit. For laboratory data, the nadir may be displayed. The nadir in a given cycle is the lowest laboratory value in that cycle; the overall nadir for a patient is the lowest laboratory value among all cycles.
- ◆ Other continuous variables (eg. Age, doses ...) are presented using median and range (minimum, maximum). If appropriate, the data may additionally be presented in categories (eg. Age may be grouped in decades in addition to the median and range being reported).
- ◆ **Dose intensity:** The dose intensity of a drug is calculated on actual treatment duration (in appropriate units of time, weeks, cycles, or days) and actual treatment dose received (total dose received expressed in appropriate units (kg, m<sup>2</sup>, ...)).
  - ◆ Whenever the treatment is given in cycles and the last planned day of treatment is not the last day of the cycle, the total duration of the treatment must account for this by adding the appropriate number of days to complete the last cycle (e.g. if treatment is given on days 1-5 of a 21-day cycle, the total treatment duration in days is [date of last injection]-[date of first injection]+1+(21-5).
  - ◆ The dose intensity (expressed in units of dose / unit of time) (e.g. mg/m<sup>2</sup>×week) is the ratio of the total dose received to the total treatment duration, for example, for a dose in mg/m<sup>2</sup> and a duration in weeks
 
$$DI_{observed} (mg / m^2 \times week) = \frac{Total\ dose\ (mg / m^2)}{Actual\ total\ treatment\ duration\ (weeks)}$$
  - ◆ The relative dose intensity is calculated as the ratio of the dose intensity as calculated above to the dose intensity indicated in the protocol, expressed in percent (%). Note that to obtain a correct ratio, the theoretical dose intensity must be expressed in the same units of dose and time as those used for the actual dose intensity. For example
 
$$DI_{protocol} (mg / m^2 \times week) = \frac{Dose\ per\ cycle\ (mg / m^2)}{Theoretical\ duration\ of\ one\ cycle\ (weeks)}$$
  - ◆ The relative dose intensity is usually presented using median and ranges, accompanied or not by a distribution into categories (e.g. ≤70%, >70-90%, >90-110%, >110-120%, >120%).

## 2.4 Contents of the chapters

**In all following sections: "by treatment arm" means "by combination of treatments" in case of trials with multiple randomizations (i.e. 4 groups in case of 2x2 factorial trials).**

**The populations used to display the various tables and analyses should be clear from the SAP/protocol.**

In general,;

- ◆ Patient availability is displayed for all patients
- ◆ Baseline characteristics and endpoint tables are displayed for the population of patients used for the primary analysis of the primary endpoint;

- ◆ Treatment exposure, safety and reasons to stop treatment are displayed for the safety population. Patients excluded from that population (those who did not start the allocated treatment) are displayed separately (in general in a listing in appendix);
- ◆ Tables of all trial primary endpoint(s) and efficacy endpoint(s) are displayed for all populations used for the analysis of these endpoints (primary or sensitivity);
- ◆ QoL compliance tables are displayed on all patients.

### **2.4.1 Summary of the trial (TSR)**

This chapter is a one-page summary of the study that forms the first chapter "study design" of the Trial Status Reports prepared by the data managers (Ref. template vstatusc.dotx).

### **2.4.2 Statistical considerations and study history**

This chapter consists of several sections detailing respectively:

- ◆ A summary of any recent or important amendments to the trial;
- ◆ The sample size and objectives of the trial (those stated in the current version of the protocol);
- ◆ A summary of any interim or other past analyses, with their conclusions, and any modifications to the trial design or analysis plan they triggered. For multi-stage studies, the results of the former stage (e.g. phase II results for a phase II/III trials, or phase I results for a phase I/II trial) must also be reported;
- ◆ A description of trial-specific quality control procedures, if any, and an explanation of how these affected the trial and/or analysis. (Do not describe the standard EORTC Quality Assurance procedures, as those are detailed in the study protocol).

### **2.4.3 Objectives of the present analysis and data selection for this report**

This section must clearly state the nature and the objectives of the analysis that is being reported (final, long term update, Quality of Life analysis, exploratory research, translational research).

For IAR, this section must also clearly state the precise questions that the Independent Data Monitoring Committee is asked to answer.

This section also reports any remarks of the Headquarters team regarding the study conduct and any problems related to data collection or data management.

The cut-off date and data selection (database cut-off date, exclusion of patients for quality reasons...). For interim analyses, the quality of the data needs to be assessed and described: outstanding queries, how definite are the main points described in the IAR.

The total number of patients randomized versus planned number, number of events reached versus planned per protocol and how the design is affected (e.g. if interim and interim boundaries need to be modified based on actual information fraction), specify it here.

### **2.4.4 Patient availability**

#### **2.4.4.1 Accrual**

This chapter provides information regarding the recruitment rate both over time and by institution and with some information regarding the compliance to the entry rate foreseen in the protocol.

The sections in this chapter include:

- ◆ For interim analyses only, a graph of the actual and expected accrual over the time since the study was open to patient entry (function “accrual” in VISTA-STAT);
- ◆ A table of the number of patients entered by institution, optionally split further by time period and/or treatment arm and/or step (in case it is a multi step study). In this table, the institutions are referred to by the institution short name rather than by institution number. The tables are sorted by descending order of total accrual;

For intergroup trials, the accrual by group is displayed in a 2-way table cross tabulating the primary group affiliation (variable “group1” as columns) versus the affiliation of the center to the EORTC (an indicator variable that takes value 1 if “EORTC” was reported in either “Group1” or “Group2”, and 0 otherwise, as rows). If the report is intended for use by EORTC only, the accrual by institution is displayed only for the centers that belong to EORTC (ie. The patients and institutions for whom “EORTC” is reported in the variables “Group1” or “Group2”); otherwise, the table is given for all centers.

#### 2.4.4.2 Follow-up

The follow-up data in the study is documented by treatment arm and overall. The follow-up duration is estimated by the inverse Kaplan-Meier method (**Error! Reference source not found.**) (i.e. doing a curve with event in curve=censored data and censored in curve=event reached in the database) and compared by the Logrank test.

The Kaplan-Meier figure is also provided in the report (by treatment arm, in general).

One notes, however, that the method may result in estimates of median follow-up that are short whenever the study is very mature (few patients alive). In that instance, the median of follow-up for patients alive may need to be documented as well.

Whenever different endpoints are followed-up differently (e.g. overall survival takes all observations, but PFS would need the time until last measurements) then several durations of follow-up ("follow-up for survival", "follow-up for progression" may need to be documented).

#### 2.4.4.3 Eligibility

This information is summarized in a table providing eligibility status by treatment arm (i.e. 4 groups in case of 2x2 factorial design), supplemented by a listing of ineligible patients (with institution number, seqid, date of entry, treatment arm, and details of the reasons of ineligibility). In case of a study with 2 or more steps, separate lists describe the patients who were ineligible to enter each step.

Patients who have been entered in the study with a waiver on some eligibility criteria (ref. CM-010-WIN-01: Management of Eligibility Compliance) must be identified clearly in the table and are considered as eligible when defining the populations used in the analysis.

#### 2.4.4.4 Patient populations used in the analysis

This section shows in a tabular format the number of patients included (by treatment arm and in total) in all the "patient populations" defined in the SAP. In general, for phase III trials, there is always the "intent-to-treat population" and the "per protocol" population for the analysis of the efficacy endpoints, and the "safety population" for the reporting of the safety endpoints. The total number entered must always appear in this

table (should it differ from the ITT population, then 2 rows must be displayed: total number randomized and number in the ITT population).

## 2.4.5 Baseline characteristics

This chapter describes the distribution of all baseline characteristics for all patients collected on the set of baseline case report forms by treatment arm. It is best organized in meaningful sections, for example:

- ◆ Demographics: age, sex (if applicable)
- ◆ Medical history: Concomitant illnesses, relevant previous illnesses, previous treatments for protocol disease, if appropriate
- ◆ Disease characteristics: TNM or other relevant classification, baseline measurements
- ◆ Baseline values of other known prognostic factors such as markers used as stratification factors.
- ◆ Baseline hematology
- ◆ Baseline biochemistry
- ◆ Baseline signs and symptoms

For multi-step trials, this section may need to be duplicated to report the status of the patients at entry in each step of the study.

It is common that the same information is available from the randomization questions and from the eligibility checklist. If stratification factors were defined for the study, these are described according to the values declared at the time of randomization. Tables describe the frequency of inconsistencies between the values of stratification factors declared during the randomization versus those updated later on (from baseline forms).

For IAR, the data provided at randomization may be used to replace missing values if the check list has not been returned.

## 2.4.6 Compliance to the protocol

### 2.4.6.1 Central medical review of compliance to protocol

This section presents in tabular format, supplemented by listings as appropriate, the central assessment (by study coordinator or according to Medical Review Plan) of the "deviations from protocol treatment".

The table is provided by treatment arm.

### 2.4.6.2 Compliance to treatment allocation

This table shows the treatment actually received versus the randomized treatment. It shows, by treatment arm: the number of patients who started the allocated treatment, the number of patients who did not start the allocated treatment with details on the reasons for not adhering to the protocol and the number of patients for whom no information is available, if any. Whenever the treatment is complex, the table may need a number of entries to represent the possible combinations of treatments received (e.g. for surgery followed by radio-chemotherapy, entries may be: "operated and received radiochemotherapy", "operated, received radiotherapy only", "operated received chemotherapy only", "operated only", "not operated (off study)").

### 2.4.6.3 Other compliance measures

This section, when relevant, describes other aspects of the compliance to the protocol, for example, compliance to the schedule of assessment for the endpoint of PFS or response.

This includes but is not limited to: tables displaying frequency of missed visits (&/or of inadequate visits – if the concept of "adequate visit" is defined in Medical Review Plan), frequency of patients lost to follow-up for survival (by > x years), deviations from scheduled visit time by arm by visit...

## 2.4.7 Exposure to treatment

This chapter describes the adherence to the theoretical main protocol treatment and the reasons for non-adherence by treatment arm. It should be organized to be concise, yet meaningful.

In most EORTC protocols, the treatment consists in a succession of different therapeutic modalities (e.g. radiotherapy/surgery/chemotherapy/others) some of which may be standard or under investigation. **When one of these therapeutic modalities is either standard or considered as a secondary question in a protocol, it is usually described with less detail than the part of the treatment that is the main study investigation.**

For each part of the treatment, a section typically describes, for all patients who started that treatment

- ◆ The summary of the total duration of exposure to the treatment (total duration of treatment, total number of cycles);
- ◆ For all patients who did not receive the full treatment, a table and/or a listing detailing the number of such patients, when they stopped the treatment and for which reason;
- ◆ A summary table of the total dose received (relative dose intensity and/or total dose (as appropriate));
- ◆ Tables of modifications of the treatment (dose reduction, dose delays, and treatment interruptions);

In general the report of the exposure to treatment is heavily driven by the information that was collected on the case report form and by medical considerations. In case of doubts on the best format to report these data, it is strongly suggested to agree on the contents and format of this chapter with the Clinical Research Physician before drafting the report.

When the protocol involves a delayed treatment, the rate of patients who have started the treatment at a given time may be estimated by cumulative incidence in all patients (with those who never started the treatment treated as competing risks, the event of interest being the start of treatment). To estimate the actual median time to starting treatment for patients who did start treatment, one may use Kaplan-Meier curves excluding the patients who never started the treatment.

## 2.4.8 Safety evaluations

### 2.4.8.1 Adverse events

In all reports, the adverse events are grouped logically according to the type of toxicity: hematological toxicity (WBC, neutrophils, platelets, hemoglobin), non hematological toxicity and by organ class (gastro-intestinal, genito-urinary, skin, neurological, pulmonary). Of note, febrile neutropenia belongs to the hematological toxicity.

In general, for phase III trials, only the worst grade of adverse event observed over a specified time period is displayed. The frequency of number of patients and % with a given grade of each adverse event is presented



by treatment arm. Extra columns may also report the total % with grade>0 and/or grade>2. For most studies, there is only one time period that consists in the complete follow-up time from start of treatment, however, some SAPs may specify different time periods (e.g. during treatment versus during follow-up after treatment, or acute versus late adverse event). When relationship is collected, tables of non hematological adverse events may need to be repeated, taking only the "related" adverse events into account.

To prepare these tables, one first reclassifies the "other adverse events" (from the non preprinted items) inside the appropriate organ class. In displaying the tables, listings are provided to describe all the adverse events that are either of particular interest to the medical reader, or for which a specification ("text field") was collected on the case report form.

It is strongly advised to discuss the format and contents of this section of the report with the Clinical Research Physician, before preparing the draft report.

### 2.4.8.2 Serious Adverse Events

This section contains the **standard tables provided by the Pharmacovigilance Unit.**

Further descriptions of the serious adverse events and toxic deaths events are added by the Clinical Research Physician.

The format of the presentation is the same as that used in the Development Safety Update Report which is, for example:

#### 2.4.8.2.1 Study safety overview per treatment arm

Trt	SAE	SAR	SUSAR	Deaths	Toxic Deaths
Arm 1: Doxorubicin	139	78	5	12	5
Arm 2: Doxorubicin + Ifosf.	354	312	4	5	2
Grand Total	493	390	9	17	7

#### 2.4.8.2.2 SUSARs by SOC and PT

Case ID	Trt	SOC	PT
62012-270-2	Arm 1: Doxorubicin	Gastrointestinal disorders	Intestinal perforation
62012-6-3	Arm 1: Doxorubicin	Gastrointestinal disorders	Steatorrhoea

#### 2.4.8.2.3 Toxic deaths by SOC and PT

Case ID	Trt	SOC	PT
62012-105-1	Arm 1: Doxorubicin	Respiratory, thoracic and mediastinal disorders	Respiratory failure
62012-143-1	Arm 1: Doxorubicin	Infections and infestations	Pneumonia

#### 2.4.8.2.4 Line Listings of Serious Adverse Reactions (SAR)

Provided in a pdf table that is placed in appendix and referred to in this chapter.

**2.4.8.2.5 Cumulative Summary Tabulation of Serious Adverse Events (SAE).**

PRIMARY SOC	PT	Arm 1: Doxorubicin	Arm 2: Doxorubicin + Ifosf.	Grand Total
Blood and lymphatic system disorders	Anaemia	3	23	26
	Febrile bone marrow aplasia		5	5
	Febrile neutropenia	19	87	106
	Leukopenia		4	4
	Neutropenia	6	35	41
	Pancytopenia		7	7
	Thrombocytopenia		27	27
Blood and lymphatic system disorders Total		28	188	216
Cardiac disorders	Cardiac arrest	1	1	2
	Cardiac failure		1	1
	Congestive cardiomyopathy	1		1
	Tachycardia		1	1

**2.4.8.2.6 Cumulative Summary Tabulations of Serious Adverse Reactions (SAR)**

PRIMARY SOC	PT	Arm 1: Doxorubicin	Arm 2: Doxorubicin + Ifosf.	Grand Total
Blood and lymphatic system disorders	Anaemia	2	22	24
	Febrile bone marrow aplasia		5	5
	Febrile neutropenia	19	87	106
	Leukopenia		4	4
	Neutropenia	6	34	40
	Pancytopenia		7	7
	Thrombocytopenia		27	27
Blood and lymphatic system disorders Total		27	186	213

**2.4.9 Reasons for stopping treatment**

This table describes for all patients who started protocol treatment, the current status of the patients (on treatment versus off treatment) with the reasons for stopping the treatment. Listings must be added whenever further details were collected in text fields.

### **2.4.10 Post-protocol therapy**

If the information was collected, then this section describes for all patients who stopped protocol treatment and for whom follow-up information is available on the additional treatment received. Listings must be added whenever further details were collected in text fields.

### **2.4.11 Post-treatment evaluations (as appropriate: response to treatment, surgery and pathology ...)**

This section is very specific to each study and may even not exist if only long term efficacy endpoints were collected.

- ◆ In case response to treatment is an endpoint, a section tabulates the response to the treatment in the patient population(s) defined in the SAP/protocol for this endpoint (e.g. patients in the ITT who presented with measurable disease). Confidence intervals around the response rates and P-values for the comparative test are given according to ST-005-SOP. Patients who cannot be evaluated are included in the denominator and reported as "non evaluable".
- ◆ If surgery is part of the study protocol, (for example in neo-adjuvant treatment trials, or if it is planned in case of relapse), then the surgery is described in a specific chapter. The data presented in this chapter depend on the intended type of surgery and the amount of collected data documenting the procedure. In general, the chapter aims at describing:
  - ◆ The number of patients who underwent surgery and a descriptive of those who did not when they should have according to the protocol, with the identification of the patients and of the reasons for non-compliance;
  - ◆ For the patients who underwent surgery, the type of surgery, the completeness of the excision is tabulated;
  - ◆ The number of patients for whom there were complications to the surgery, the description of these complications and their outcome;
  - ◆ If local and/or central histopathology of the resected specimens is available, the histopathology result (pathological response or else). If both local and central reviews were performed, one either reports both in separate sections unless the SAP clearly indicates that the central review supersedes the local assessment.

### **2.4.12 Disease status (includes tables of frequency of events, sequence of events)**

This section displays the frequency of all events and combinations of events of interest by treatment arm in the primary analysis set. If sensitivity analyses are conducted in alternative patient populations, separate tables tabulate the events in the various analysis sets.

The chapter on efficacy is usually subdivided in several sections according to the endpoint that is considered survival status and cause of death (with listings describing the "other" and "toxic" deaths and any other cause of death for which further details were collected in text fields), progression status (local, regional distant), second cancers, disease-free survival etc..

For composite endpoints such as progression-free survival, it is recommended to also tabulate the type of first event that was considered in the endpoint.

When cumulative incidence analyses are planned, it may be of interest to tabulate or present in flow charts the sequence of events (e.g. Local progression, then distant, then died) and number of patients who had the given sequence of events.

### **2.4.13 Statistical inference on efficacy endpoints (clearly identify which analyses are primary/secondary/exploratory)**

This chapter is subdivided in sections, with one section by endpoint and one subsection by analysis. The primary analysis of each endpoint must be clearly identified. Tables of results and figures are provided and computed according to ST-005-SOP.

### **2.4.14 Compliance to Quality of Life (QoL, if collected in the study)**

Two tables are produced to document the compliance to quality of life assessments. Both are readily produced using an EORTC SAS macro (%QoLComp\_V or later versions).

- ◆ The first table presents the compliance by assessment time (number of forms received, number of forms due, % received). For final reports of primary efficacy results, the frequencies are displayed by treatment arm but they may be given overall for interim analysis reports.
- ◆ The second presents by institution the % of baseline forms and of follow-up quality of life forms that were received.

### **2.4.15 Summary of the results**

This chapter gives a short summary text (1 page) of the main features and statistical conclusions of a study, to help the reader appreciate the study results. It is very similar in contents to a congress abstract.

It is written by the Statistician and the Clinical Research Physician (safety).

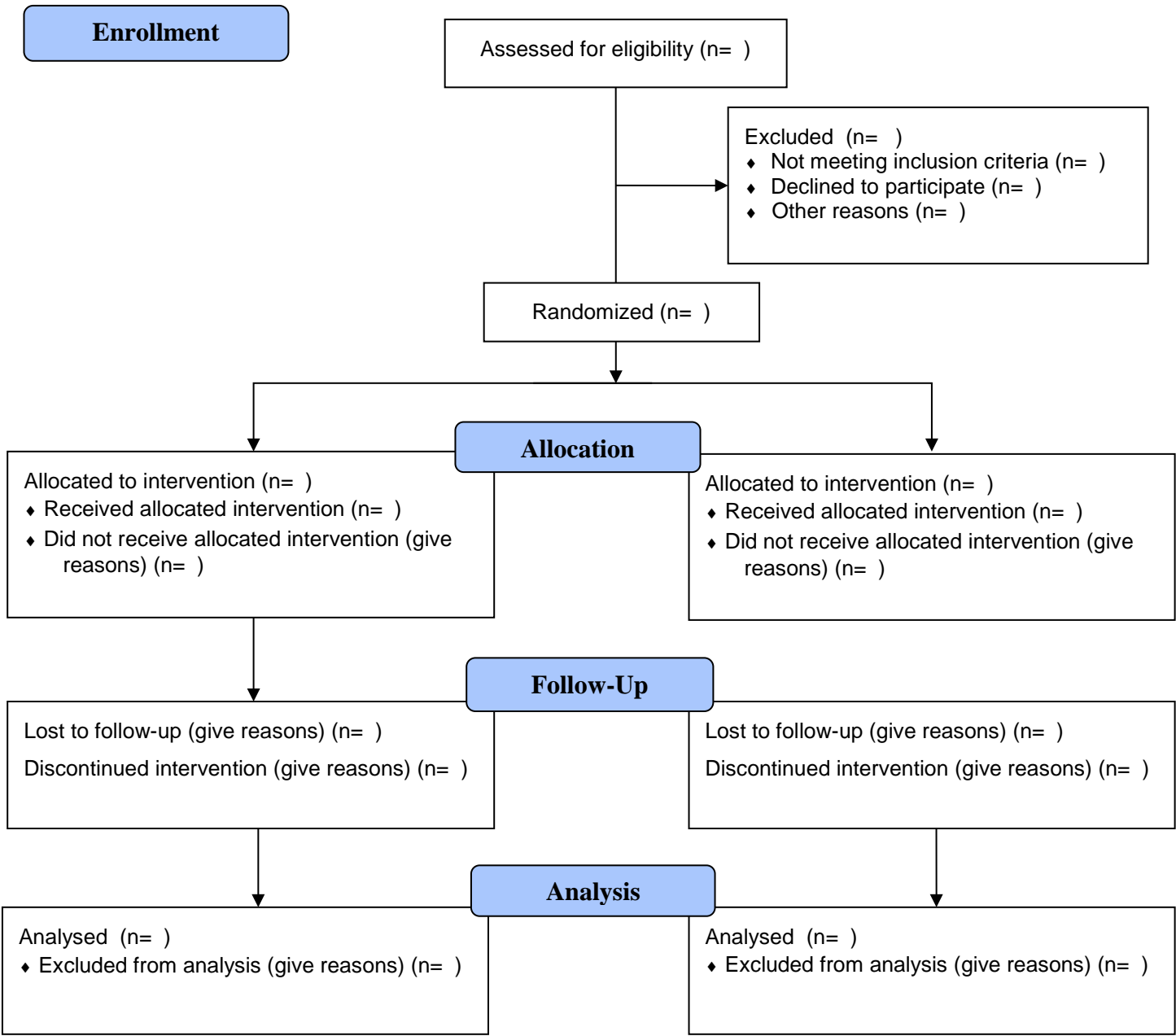
The chapter is structured in paragraph covering the following aspects:

- ◆ Recruitment, compliance to protocol
- ◆ Exposure to treatment
- ◆ Safety results
- ◆ Efficacy results
- ◆ Conclusions

### **2.4.16 CONSORT Flow Chart**

For Final Analysis Reports, a CONSORT Flow Chart must be prepared according to the current recommendations (<http://www.consort-statement.org/consort-statement/>). It may alternatively be placed in appendix.

The 2010 Consort Flow Chart looks as follows



### 2.4.17 Short Study Report for Health Authorities

**This report is optional for Interventional Clinical Trials that ended on or after 21 July 2014. Instead, as of 21 July 2014, it will become mandatory for sponsors to post clinical trial results in the European Clinical trials Database (EudraCT), managed by the European Medicines Agency (EMA).**

In case this report is provided, it includes a summary of the study and study results in the format recommended by ICH E3 for “Short Synopsis”. It is presented in as separate document from the FAR but must have the same date as the FAR.

Most of the information required to complete this short report is readily available from

- ◆ The protocol "summary" section;
- ◆ The accrual tables;
- ◆ The section "Summary of the results" in the FAR of efficacy results (and quality of life);
- ◆ The bibliography.

## 3 ASSOCIATED DOCUMENTS

Document title	Reference (file name or path)
CONSORT guidelines	<a href="http://www.consort-statement.org/consort-statement/">(http://www.consort-statement.org/consort-statement/)</a> .
Template for Short Study Report to Health Authorities	ST-006-AF-01
Analysis report template	ST-006-AF-05

Forms are available from:

- Intranet, documentation section, Electronic Library of Quality Standard Documents page
- MS Word, File tab, New, My templates, forms tab, select the form

## 4 DOCUMENT HISTORY

Version N°	Brief description of change	Author	Effective date
1.00	Initial release; supersedes (WP1302 version 4.1) for phase III trials	Laurence Collette	25 Feb 2011
1.00	No change	Laurence Collette	25 Feb 2014
2	Addition of a section to report “Post-protocol therapy” + Short Study Report for Health Authorities optional for Interventional Clinical Trials that ended on or after 21 July 2014 (EudraCT) + Minor edits	Saskia Litière	19 Jan 2015