

# **Chemotherapy in Non-Small Cell Lung Cancer: An Update**

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***A meta-analysis of randomised trials using individual patient data***

***Protocol C***

***Comparison 3***

***Surgery + Radiotherapy vs Surgery + Radiotherapy + Adjuvant Chemotherapy***

Conducted by  
the Non-Small Cell Lung Cancer Collaborative Group (NSCLCCG)

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## **NSCLC Collaborative Group**

### **Secretariat**

#### **Comparisons 1, 2 & 7 please contact**

Meta-analysis Group  
MRC Clinical Trials Unit  
222 Euston Road  
London  
NW1 2DA  
UK  
Fax: +44 (0)20 7670 4816

**Sarah Burdett**  
email: [sb@ctu.mrc.ac.uk](mailto:sb@ctu.mrc.ac.uk)  
tel: +44 (0)20 7670 4722

Lesley Stewart  
email: [ls@ctu.mrc.ac.uk](mailto:ls@ctu.mrc.ac.uk)  
tel: +44 (0)20 7670 4724

Richard Stephens  
email: [rs@ctu.mrc.ac.uk](mailto:rs@ctu.mrc.ac.uk)  
tel: +44 (0)20 7670 4737

#### **Comparisons 3, 4, 5 & 6 please contact**

Service de Biostatistique et d'Epidemiologie  
Institut Gustave-Roussy  
rue Camille Desmoulins  
94805 Villejuif cedex  
France  
Fax: +33 (0)1 42 11 52 58

Anne Auperin  
email: [auperin@igr.fr](mailto:auperin@igr.fr)  
tel: 33 (0) 1 42 11 54 99

**Jean-Pierre Pignon**  
email: [jppignon@igr.fr](mailto:jppignon@igr.fr)  
tel: 33 (0) 1 42 11 45 65

Thierry Le Chevalier  
email: [tle-che@igr.fr](mailto:tle-che@igr.fr)  
tel: 33 (0) 1 42 11 43 22

Cecile Le Pechoux  
email: [lepechoux@igr.fr](mailto:lepechoux@igr.fr)  
tel: 33 (0) 1 42 11 47 57

### **International Advisory Group**

R Arriagada, Instituto de Radiomedicina (IRAM), Santiago 34, Chile  
J Higgins, MRC Biostatistics Unit, Cambridge, UK  
D Johnson, Vanderbilt-Ingram Cancer Center, Nashville, TN, USA  
J van Meerbeeck, University Hospital, Ghent, Belgium  
M Parmar, MRC Clinical Trials Unit, London, UK  
R Souhami, Cancer Research UK, London, UK

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Protocol C

surgery + radiotherapy vs surgery + radiotherapy + chemotherapy

## Introduction

More than a million new cases of lung cancer are diagnosed each year<sup>1</sup>. About 80% of these tumours are of non-small cell histological type<sup>2</sup>, including adenocarcinomas, squamous cell and large cell carcinomas. Non-small cell lung cancer (NSCLC) is the main cause of deaths from cancer and five-year survival across all stages of disease is about 14%<sup>3</sup>.

Surgery is generally regarded as the best treatment option, but only about 30% of tumours are suitable for potentially curative resection<sup>4</sup>. A further 20% of patients, usually those presenting with locally advanced disease, undergo radical thoracic radiotherapy. The remaining 50% of patients, with late stage or metastatic disease, are usually treated palliatively.

In 1991, the British Medical Research Council's Cancer Trials Office (MRC), Cambridge; the Institut Gustave Roussy (IGR), Villejuif, France; and the Istituto Mario Negri (IMN), Milan, Italy initiated an individual patient data (IPD) meta-analysis to assess the role of chemotherapy in the treatment of NSCLC. At that time, despite over thirty years of research involving more than 9000 patients in over 50 randomised clinical trials (RCTs), the efficacy of chemotherapy, when combined with local treatment or supportive care, was unclear. With few exceptions, most trials were too small to reliably detect moderate treatment effects. Consequently, although a few trials reported significant results, both for and against chemotherapy, most trials were inconclusive.

This IPD approach to meta-analysis and systematic review involved the central collection, validation and analysis of the original trial data. It did not rely on data extracted from publications. At the outset, the secretariat contacted the investigators responsible for each trial and established the NSCLC Collaborative Group on whose behalf the meta-analysis was carried out and published in the British Medical Journal in 1995<sup>5</sup>. This has become a 'landmark publication' and was cited nearly 900 times between 1995-2003.

The meta-analysis concluded that despite previous scepticism and controversy, modern chemotherapy could have a role in treating NSCLC. In particular, there was strong evidence that for more advanced disease, chemotherapy given in addition to radical radiotherapy and given in addition to best supportive care, prolonged survival. The results for early stage disease, although in favour of chemotherapy, were less clear-cut. A fuller presentation of the results of the meta-analysis published in 1995 is given in Box 1.

The results suggested survival benefits are moderate (~ 5%) but potentially important and that there was no good evidence that any subgroup of patients (age, sex, stage, histology, performance status) benefits more or less than any other group

Since the meta-analysis was published, there has been renewed enthusiasm for investigations of chemotherapy in NSCLC and a considerable number of new RCTs have been completed. The total number of patients randomised has approximately doubled from 9387 to over 19000 patients. In particular, there have been many new trials in the surgical setting including trials of neoadjuvant chemotherapy. A number of new agents and timings have been investigated in all settings. As the aim of the NSCLC Collaborative Group is to provide an up to date and reliable review of the role of chemotherapy, both to act as a sound basis for evidence based medicine and to help guide future research, it is now timely to undertake a major update and re-evaluation of the 1995 meta-analysis.

Seven therapeutic comparisons will be explored:

- 1 surgery vs surgery + adjuvant chemotherapy
- 2 surgery vs neoadjuvant chemotherapy + surgery
- 3 surgery + radiotherapy vs surgery + radiotherapy + adjuvant chemotherapy**
- 4 radiotherapy vs radiotherapy + sequential chemotherapy (neoadjuvant – before radiotherapy- and/or adjuvant –after radiotherapy) or alternated radio-chemotherapy
- 5 radiotherapy vs radiotherapy + concomitant chemotherapy
- 6 radiotherapy + sequential chemotherapy vs radiotherapy + concomitant chemotherapy
- 7 supportive care vs supportive care + chemotherapy

Three of these comparisons (2, 5 and 6) are new; this reflects changes in practice and interest since the 1995 Meta-analysis and ensures that this systematic review is as inclusive and comprehensive as possible.

For clarity a separate protocol has been produced for each individual comparison, each of which can be considered as an independent meta-analysis, but when considered together will allow us to evaluate the overall picture of chemotherapy in non-small cell lung cancer.

This protocol relates to **comparison 3** of the meta-analysis, copies of all protocols are available on request or can be downloaded from <http://www.ctu.mrc.ac.uk/download.asp> or [http://www.igr.fr/php/index.php?ids\\_path=2.51.70.127.567](http://www.igr.fr/php/index.php?ids_path=2.51.70.127.567)

The meta-analyses will be jointly run by the Medical Research Council and the Institut Gustave Roussy. See Appendix D for further meta-analyses completed by these two groups.

**Box 1****Summary of Results of 1995 Meta-analysis<sup>1</sup>**

The main objective of the meta-analysis was to investigate the effect of chemotherapy on survival when given in addition to appropriate local treatment:-

*Early disease*

surgery versus surgery + chemotherapy

surgery + radiotherapy versus surgery + radiotherapy + sequential chemotherapy

*Locally advanced disease*

radical radiotherapy versus radical radiotherapy + sequential chemotherapy

*Advanced disease*

supportive care versus supportive care + chemotherapy

Trials were classified as belonging to one of four pre-specified categories of chemotherapy

-Regimens containing cisplatin

-Regimens using long-term alkylating agents (but not cisplatin)

-Regimens containing etoposide or vinca alkaloids (but not cisplatin)

-Other regimens

**Results**

Comparison	Hazard Ratio	Confidence Interval	p-value
<b>Surgery vs surgery + chemotherapy</b>			
Long-term alkylating agents	1.15	1.04-1.27	0.005
Other drugs	0.89	0.72-1.11	0.30
Cisplatin based	0.87	0.74-1.02	0.08
<b>Surgery + RT vs surgery + RT + chemotherapy</b>			
Long-term alkylating agents	1.35	0.83-2.20	0.23
Cisplatin based	0.94	0.79-1.11	0.46
<b>Radical RT vs radical RT + chemotherapy</b>			
Long-term alkylating agents	0.98	0.83-1.16	0.81
Vinca-alkaloids	0.87	0.70-1.09	0.23
Other drugs	0.98	0.74-1.29	0.88
Cisplatin based	0.87	0.79-0.96	0.005
<b>Supportive care vs supportive care + chemotherapy</b>			
Long-term alkylating agents	1.26	0.96-1.66	0.095
Vinca-alkaloids / etoposide	0.87	0.64-1.20	0.40
Cisplatin based	0.73	0.63-0.85	<0.0001

A further objective was to assess whether any possible effects were consistent in the subgroups of age, sex, extent of disease, tumour stage, histology and performance status. Subgroup analysis of trials using cisplatin based regimens found no indication that any particular type of patient benefited more or less from chemotherapy.

**Conclusions**

The results were consistent across primary treatment settings and they tended to show a benefit of modern cisplatin-based chemotherapy regimens although essential drugs were not identified.

<sup>1</sup> Non-small Cell Lung Cancer Collaborative Group. Chemotherapy in non-small cell lung cancer: a meta-analysis using updated data on individual patients from 52 randomised clinical trials. British Medical Journal 1995;311:899-909.

## Methods

### Design

A systematic review and quantitative meta-analysis based on updated individual patient data will be carried out. This approach involves the central collection, validation and analysis of data from all patients from all relevant randomised trials.

### Treatment comparisons

Seven meta-analyses will be carried out over three main clinical settings, corresponding to the stage of disease and to the primary treatment

#### Surgery

- 1 surgery vs surgery + adjuvant chemotherapy
- 2 surgery vs neoadjuvant chemotherapy + surgery
- 3 **surgery + radiotherapy vs surgery + radiotherapy + adjuvant chemotherapy**

#### Radiotherapy

- 4 radiotherapy vs sequential radiotherapy + sequential chemotherapy
- 5 radiotherapy vs radiotherapy + concomitant chemotherapy
- 6 radiotherapy + sequential chemotherapy vs radiotherapy + concomitant chemotherapy

#### Supportive care

- 7 supportive care vs supportive care + chemotherapy

### Identification of trials

There is good evidence that investigators and journals alike are more likely to publish trials with positive results<sup>6-8</sup>. In order to avoid such publication bias, both published and unpublished trials will be included in the meta-analysis. To identify as many relevant trials as possible, systematic searches of a number of trial sources will be carried out and updated during the course of the project, ensuring a comprehensive and up-to-date database of trials.

#### *Electronic Databases*

The optimum search strategy for retrieving randomised controlled trials (RCTs) from Medline, developed by the Cochrane Collaboration<sup>9</sup> will be modified (Appendix B).

- To specifically retrieve RCTs of chemotherapy for NSCLC
- And used to search Medline and Cancerlit

In addition the following electronic bibliographic databases will be searched.

- The Cochrane Central Register of Controlled Trials (CENTRAL)
- Proceedings of ASCO 1995 - 2003

#### *Trial Registers*

Trial registers will be used to supplement searches of electronic databases with trials that may not (yet) be published or are still recruiting patients:

- UKCCCR Trials Register
- ClinicalTrials.gov
- Physicians Data Query Protocols (open and closed)
- Current Controlled Trials 'metaRegister' of controlled trials



*Hand Searches*

The following hand searches will be carried out with the aim of identifying trials that may have only been reported as abstracts or that might have been missed in the searches described above:

- Proceedings of the American Society for Clinical Oncology (ASCO) 1993-2003
- Proceedings of the IASLC World Lung Cancer Conference 1997-2003
- Proceedings of the European Society of Medical Oncology (ESMO) 1996 - 2002
- Proceedings of the European Cancer Conference Organization (ECCO) 1995 - 2003
- Bibliographies of all identified trials and review articles will be searched

*Experts in the field*

All participating trialists will be asked to review and supplement a provisional list of trials

## Eligibility criteria

### 3 surgery + radiotherapy vs surgery + radiotherapy + adjuvant chemotherapy

#### Trials must

- be properly randomised in a way which precludes prior knowledge of treatment assigned
- be unconfounded
- have commenced randomisation on or after January 1<sup>st</sup> 1965
- have completed accrual before 2003 (ongoing trials will be listed but no data collected)
- have included patients with non-small cell lung cancer
- have compared first-line therapy

#### Patients must

- have undergone a potentially curative operation
- be randomised to receive postoperative radiotherapy and adjuvant chemotherapy or postoperative radiotherapy only
- not have received prior chemotherapy
- not have had any prior malignancy

## Data Collection

#### *New Trials*

For all new trials, basic survival and baseline characteristics will be sought for **all** patients randomised into each trial. Up to date follow-up will be requested in order to report on both short and longer-term outcomes.

patient identifier (preferably not patient name)

date of birth or age at randomisation

sex

performance status

extent of resection (complete/incomplete)

pathological tumour stage(pTNM)

histology

date of randomisation

treatment allocated

chemotherapy regimen

survival status

date of last follow-up

date of death

cause of death

whether excluded from trial analysis

reason for exclusion

local recurrence status

date of local recurrence

distant recurrence status

date of distant recurrence

#### *Trials already included in the 1995 Meta-analysis*

Trials of long-term alkylating agents will not be updated as these are old trials that provided mature data for the 1995 analysis.

For the remaining trials of adjuvant chemotherapy included in the 1995 meta-analysis, we will seek data on the additional endpoints of local and distant recurrence. Where possible we will

also obtain updated follow-up information for those patients that were alive at the time of the previous data submission.

Suggested coding conventions for these data are provided (Appendix C) and although using them will facilitate data transfer, it is not essential. Data will be accepted in whatever format is most convenient for the individual trial investigator or data centre and can be supplied by email, computer disk, on data collection forms or as a computer printout. We will also ask for a limited amount of information on trial design as well as the original trial protocol, associated on-study forms and publications

A final copy of the data from each trial will be returned to the trialists for verification. The data collation and checking for **this comparison** will be done by the **IGR**. Copies of the final agreed database of all trials included in all comparisons will be held by the MRC and the IGR. All trial data will be held securely and will not be used, circulated or distributed in any way that allows access to individual trial data, without first seeking permission from trial investigators.

## Analysis

The ultimate aim will be to obtain and analyse data from all randomised patients included in all of the relevant randomised trials.

The analysis will be performed on the endpoint of overall survival. Additional analyses will be performed on the endpoints of local recurrence-free survival, distant recurrence-free survival and overall recurrence-free survival, if sufficient data are available.

All analyses will be of randomised patients and will be carried out by intention to treat, that is, patients will be analysed according to the treatment allocated, **irrespective** of whether they received that treatment. Survival analyses will be stratified by trial, and the log-rank expected number of deaths and variance will be used to calculate individual and overall pooled hazard ratios by the fixed-effect model<sup>10</sup>. Thus, the times to death for individual patients will be used within trials to calculate the hazard ratio, representing the overall risk of death for patients who were allocated chemotherapy compared to those who were not.

Results will also be presented as absolute differences at relevant time points calculated from the hazard ratio and baseline event rate for patients not allocated chemotherapy;<sup>11</sup> proportional hazards are assumed. Confidence intervals for absolute differences will be similarly calculated from the baseline event rate and the hazard ratio at the 95% CI boundary values.  $\chi^2$  heterogeneity tests<sup>5</sup> will be used to test for gross statistical heterogeneity, the  $I^2$  statistic<sup>12</sup> will be used as a measure of consistency. Survival curves will be presented as simple (non-stratified) Kaplan-Meier curves<sup>13</sup>. All p-values will be two-sided.

## Analyses by trial level characteristics

The effect of chemotherapy may vary across trials in the meta-analysis because they have each applied treatment in different ways. To explore this further, providing that there are sufficient data available, analyses are planned whereby trials, or arms within trials, will be grouped according to the type of chemotherapy regimen to determine whether there are any differences in treatment effect between these groups.

Trial characteristics will be reported in tabular form, information will include patient numbers, period of recruitment, treatment details and proportion of patients who received second-line treatment.

### *Type of chemotherapy*

It is not practical to look at groups of trials using only exactly the same regimens, nor is it appropriate or sensible to look overall at all trials. We therefore plan to split trials into broad groupings according to the type of chemotherapy used. This will build on the groupings used in the 1995 meta-analysis, which revealed that old trials using long-term oral alkylating agents had a detrimental effect whereas trials using modern regimens showed a beneficial effect

Within each main treatment comparison, trials will be grouped by the type of chemotherapy regimen. If there are insufficient numbers of patients within any categories, categories may be combined.

**Platinum based regimens**

platinum + vinca alkaloid / etoposide  
platinum + anti-metabolic agent (e.g. tegafur, uft)  
platinum + taxane  
other platinum regimen

**Non-platinum based regimens**

vinca alkaloid / etoposide only  
anti-metabolic agent only  
taxane only  
other non-platinum regimen

**Long-term alkylating agents**

Owing to the results of the 1995 meta-analysis, long-term alkylating agents will be considered separately from other trials. Owing to their antiquity, these will not be updated and results will remain unchanged but will be included for completeness.

For these analyses a hazard ratio will be calculated for each trial and a pooled hazard ratio calculated for each treatment category. A test for interaction will be used to investigate if there are any substantial differences in the effect of treatment between these treatment categories. If there is no clear evidence of heterogeneity results may also be combined over categories.

**Sensitivity Analyses**

Hazard ratios for overall survival will also be calculated using a random effects model.

Hazard ratios for overall survival will also be calculated excluding any trials that are clear outliers.

**Analyses by patient level characteristics**

Providing there are sufficient data available, we will investigate whether any observed treatment effect is consistent across well-defined patient subgroups. These analyses will be carried out on all trials (except trials of long-term alkylating agents) and will be stratified by trial. If there are substantial heterogeneity and differences of effect between treatment categories, then subgroup analyses will be done within treatment categories.

If there are insufficient numbers of patients within any patient categories, categories will be combined. Chi-squared tests for interaction or trend will be used to test whether there is any evidence that particular types of patients benefit more or less from chemotherapy.

The subgroups are as follows:

**Age** (<60, 60-64, 65-69, 70+)

**Sex** (Male, Female)

**Performance Status** \*(Good, Poor)

**Histology** (Adenocarcinoma, Squamous, Large cell, Other)

**Stage** \*\*See below for calculation

**Extent of Resection** (Complete, Incomplete)

\*Performance Status

Meta-analysis Performance Status	WHO / ECOG	Karnofsky
Good	0, 1	100, 90, 80, 70
Poor	2, 3, 4	60 - 10

\*\*Stage

Meta-analysis Stage / ISS 1986	(p)TNM Classification			AJCC Stage	UICC stage 1997
	(p)T	(p)N	(p)M		
I	0,1,2,X,S	0	0	I	IA, IB
II	0,1,2,X,S	1	0	II	IIA, IIB without T3N0
IIIA	a) 3 b) 1-3	a) 0-1 b) 2	0	III non metastatic	IIIA + T3N0
IIIB	4, Any N	3, Any T	0	III non metastatic	IIIB
IV	Any	Any	1	Any metastatic	IV

### Alternative exploratory analysis

Given the large number of trial and patient characteristics of interest, there may be interactions between them that could potentially confound these analyses. If we encounter substantial heterogeneity within any of the seven main meta-analyses we will further explore the potential influence of these factors using multi-level modelling techniques.

This modelling aspect of the project will be developed in collaboration with Dr Julian Higgins from the MRC Biostatistics Unit, who is a member of the International Advisory Group.

## Publication Policy

The results of the meta-analyses will be published and presented in the name of the NSCLC Collaborative Group comprising trialists contributing data for analysis, the Secretariat and Advisory Group. Following publication in a peer reviewed journal, the meta-analyses will be submitted to the Cochrane Library to appear in the Cochrane Database of Systematic Reviews.

The seven meta-analyses will be analysed separately. We aim to have one collaborators meeting, at which the results will be presented, but the comparisons may be published separately.

The IGR carried out an individual patient data meta-analysis of concomitant chemotherapy (cisplatin or carboplatin) and radiotherapy in locally advanced non-small cell lung cancer. The results were presented at the 2003 World Conference on Lung Cancer in the name of the MAC3C-LC (meta-analysis of cisplatin/carboplatin based concomitant chemotherapy in non-small cell lung cancer) Group<sup>14</sup>. This study will be published in the name of this group. The update of this meta-analysis as well as the updating of the comparison on sequential radio-chemotherapy versus radiotherapy alone (comparison 4) and the direct comparison of these two types of radio-chemotherapy (comparison 6) will be published in the name of the current collaborative group.

## Project Administration

As for the 1995 Meta-analysis, the MRC and the IGR will share project administration.

Comparisons 1, 2 & 7

The MRC will be responsible for all contact, data collection, verification and analysis for these comparisons.

**Comparisons 3, 4, 5 & 6**

**The IGR will be responsible for all contact, data collection, verification and analysis for these comparisons.**

## Contacting Trialists

### *New trials*

Trialists will be contacted, informed of the project, invited to collaborate and asked to supply data as outlined in the methods section.

### *Trials already included in the NSCLCCG Database*

Trials of long-term alkylating agents will not be updated as these are old trials that provided mature data for the 1995 analysis.

For remaining trials, trialists will be contacted and asked to provide recurrence data and additional follow-up as appropriate. Where possible we will also obtain updated follow-up information for those patients that were alive at the time of the previous data submission.

## Timetable

Spring 2004	Write to Trialists seeking collaboration
Spring 2004-Spring 2005	Collate, check and verify incoming data, analyse individual trials
Summer 2005	Analyses
Autumn 2005	Present results to Trialists

### Comparison 3

#### surgery + radiotherapy vs surgery + radiotherapy + chemotherapy

Trial	Period of recruitment	Drugs	Number of patients	Notes
<b>Long term alkylating agent</b>				
EORTC 08741 <sup>15</sup>	1973-79	Lo, Cy, Mx	136	Comparison 1 and 3
		subtotal	136	
<b>Platinum + vinca alkaloid / etoposide</b>				
MSKCC 80-53 <sup>16</sup>	1981-87	C, Vd	72	Complete and incomplete resection
GETCB 01CB82 <sup>17</sup>	1982-86	A, Vc, C, Lo	267	
EORTC 08861 <sup>unpublished</sup>	1986-90	C, Vd	22	
*RICUM <sup>18</sup>	1983-??	C, Vd	144	Comparison 1 and 3
*INT 0115 <sup>19</sup>	1991-97	C, Et	462	Concomitant radiochemotherapy
*MDA DM 87045 <sup>unpublished</sup>	?	C, Cy, Et	80	Incomplete resection only
*Anita 1	1994-00	C, Vn	??	Comparison 1 and 3
*BLT <sup>20</sup>	1995-01	(C, Vd) or (C, Vn) or (C, Mi, If) or (C, Mi, Vn)	70	Comparison 1 and 3
*IALT <sup>21</sup>	1995-01	(C, Vb) or (C, Vd) or (C, Vn) or (C, Et)	560	Comparison 1 and 3
*ALPI <sup>22</sup>	1994-99	C, Vd, Mi	470	Comparison 1 and 3
*Wolf <sup>23</sup>	1996-00	C, If	150	
		subtotal	>2357	
<b>Other Platinum Regimens</b>				
LCSG 791 <sup>24</sup>	1979-85	Cy, A, C	172	Incomplete resection only
FLCSG3 <sup>unpublished</sup>	1982-87	Cy, A, C	86	Incomplete resection only
*Kim <sup>25</sup>	2000-02	C, Vn	60	
		subtotal	258	
<b>Anti-metabolic agent only</b>				
OLCSG 1d <sup>26</sup>	1983-87	C, Tg	49	
		subtotal	49	
		<b>Total</b>	<b>&gt;2800</b>	

#### Ongoing Trials or trials ending after 2002

None was identified

\*Trials completed since 1995 Meta-analysis

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## Appendix A

### Glossary of Drugs

A	Doxorubicin
B	Bleomycin
Bu	Busulphan
C	Cisplatin
Cb	Carboplatin
Cy	Cyclophosphamide
Dx	Docetaxel
E	Epirubicin
Et	Etoposide
G	Gemcitabine
If	Ifosfamide
Lo	Lomustine / CCNU
Me	Mesna
Mi	Mitomycin C
Mx	Methotrexate
Mxa	Mitoxantrone
NM	Nitrogen Mustard
OF	Oral Ftorafur
Pc	Procarbazine
Pe	Pepleomycin
Pm	Porfiromycin
Pr	Prednisolone
Px	Paclitaxel
Tg	Tegafur
Ti	Tirapazamine
Tn	Teniposide
U	UFT (Tegafur + uracil)
Vb	Vinblastine
Vc	Vincristine
Vd	Vindesine
Vn	Vinorelbine

## Appendix B

### Search Strategy for Medline

- 1 Randomized Controlled Trial.pt.
- 2 exp Randomised Controlled Trials/
- 3 exp Random Allocation/
- 4 exp Double-Blind Method/
- 5 exp Single-Blind Method/
- 6 1 or 2 or 3 or 4 or 5
- 7 clinical trial.pt.
- 8 exp Clinical Trials/
- 9 clin\$ with trial.ab,ti.
- 10 (sing\$ or doubl\$ or trebl\$ or tripl\$ with blind\$ or mask\$).ab, ti.
- 11 exp Placebos/
- 12 placebo\$.ab,ti.
- 13 random\$.ab,ti.
- 14 exp Research Design/
- 15 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14
- 16 exp Carcinoma/
- 17 exp Lung Neoplasms/
- 18 (lung adj carcinoma\$).ab,ti.
- 19 (lung adj cancer\$).ab,ti.
- 20 (lung adj neoplasm\$).ab,ti.
- 21 cancer with lung.ab,ti.
- 22 carcinoma with lung.ab,ti.
- 23 16 or 17
- 24 18 or 19 or 20 or 21 or 22
- 25 exp Drug Therapy/
- 26 drug therapy.ab,ti.
- 27 chemotherapy.ab,ti.
- 28 25 or 26 or 27
- 29 exp radiotherapy/
- 30 radiotherapy.ab,ti.
- 31 29 or 30
- 32 exp surgery/
- 33 surgery.ab,ti.
- 34 32 or 33
- 35 28 or 31 or 34
- 36 6 or 15
- 37 36 and 24 and 35

## Appendix C

### Suggested coding

Please provide data on all patients randomised. You may complete data forms (provided on request) or supply your data as a computer printout, on floppy disk (formatted for PC) or by email. Data can be in almost any format (ASCII, Excel, Dbase, FoxPro etc.), but please indicate which format has been used. It would be helpful if you used the coding suggested, however you may code the data in the way that is most convenient for you. Please supply us with full details of the data coding system used. If sending data via email, please encrypt the data and let us know how it has been encrypted in a separate email.

#### *Patient Identifier*

##### **Preferably not name**

Type	character
Width	15

#### *Date of Birth*

Type	date
Width	8 or 6
Code	date in dd/mm/yyyy (recommended) or dd/mm/yy format

#### *Age*

Type	numeric
Width	3
Code	age in years unknown = 999

#### *Sex*

Type	numeric
Width	1
Code	1=male 2=female 9=unknown

#### *Extent of resection*

Type	numeric
Width	1
Code	1=complete 2=incomplete 3=no surgery 9=unknown

#### *Tumour stage used*

Type	numeric
Width	1
Code	1=pTNM 2=AJCC 3=1986 ISS 4=1997 UICC

#### **If pTNM used**

##### *Tumour Stage pTNM*

Type	character		
Width	3		
Code	pT Stage	pN Stage	pM stage
	0=pT0	0=pN0	0=pM0
	X=pTX	1=pN1	1=pM1
	S=pTis	2=pN2	9=Unknown
	1=pT1	3=pN3	

			2=pT2 3=pT3 4=pT4 9=Unknown	9=Unknown
<b>If AJCC used</b>				
<i>Tumour Stage AJCC</i>				
	Type		numeric	
	Width		1	
	Code		1=stage 1 2=stage 2 3=stage 3 4=metastatic 9=unknown	
<b>If ISS used</b>				
<i>Tumour Stage 1986 ISS</i>				
	Type		numeric	
	Width		1	
	Code		1=stage 1 2=stage 2 3=stage 3A 4=stage 3B 5=stage 4 9=unknown	
<b>If 1997 staging used</b>				
<i>Tumour Stage 1997 UICC</i>				
	Type		numeric	
	Width		1	
	Code		1=stage 1A 2=stage 1B 3=stage 2A 4=stage 2B 5=stage 3A 6=stage 3B 7=stage 4 9=unknown	
<b>Histology</b>				
	Type		numeric	
	Width		1	
	Code		1=small cell 2=adenocarcinoma 3=squamous 4=mixed 5=large cell undifferentiated 6=NSC unspecified 7=other 9=unknown	
<b>Performance Status (Karnofsky)</b>				
	Type		numeric	
	Width		3	
	Code		10-100 999=unknown	
<b>Performance Status (WHO/ECOG)</b>				
	Type		numeric	
	Width		1	
	Code		0-4 9=unknown	

*Treatment Allocated*

Type	numeric
Width	1
Code	1=surgery + radiotherapy 2=surgery + radiotherapy + chemotherapy If more than 1 regimen of chemotherapy used, please specify and use 3,4,5 etc for each different regimen

*Date of Randomisation*

Type	date
Width	8 or 6
Code	date in dd/mm/yyyy (recommended) or dd/mm/yy format

*Survival Status*

Type	numeric
Width	1
Code	0=alive 1=dead

*Date of Death /  
Last Follow-up*

Type	date
Width	8 or 6
Code	date in dd/mm/yyyy (recommended) or dd/mm/yy format

*Cause of Death*

Type	numeric
Width	1
Code	1=lung cancer 2=treatment related 3=other 9=unknown

*Local Recurrence Status*

Type	numeric
Width	1
Code	0=no recurrence 1=recurrence 9=unknown

*Date of Local Recurrence*

Type	date
Width	8 or 6
Code	date in dd/mm/yyyy (recommended) or dd/mm/yy format

*Distant Recurrence Status*

Type	numeric
Width	1
Code	0=no recurrence 1=recurrence 9=unknown

*Date of Distant Recurrence*

Type	date
Width	8 or 6
Code	date in dd/mm/yyyy (recommended) or dd/mm/yy format

*Recurrence Status (unspecified local or distant)*

Type	numeric
Width	1
Code	0=no recurrence 1=recurrence 9=unknown

*Date of Recurrence (unspecified local or distant)*

Type	date
Width	8 or 6
Code	date in dd/mm/yyyy (recommended) or dd/mm/yy format

*Excluded*

Type	numeric
Width	1
Code	0=included in analysis 1=excluded from analysis 9=unknown

*Reason for Exclusion*

Type	character
Width	25

## Appendix D

### Completed Individual Patient Data Meta-analyses by MRC and IGR

#### Meta-analysis Group, Medical Research Council, UK

Advanced Ovarian Cancer Trialists Group. Chemotherapy in advanced ovarian cancer: an overview of randomised clinical trials. *British Medical Journal* 1991;303:884-93.

Advanced Bladder Cancer Overview Collaboration. Does neo-adjuvant cisplatin-based chemotherapy improve the survival of patients with locally advanced bladder cancer: a meta-analysis of individual patient data from randomised clinical trials. *British Journal of Urology* 1995;75:206-13.

Non-small Cell Lung Cancer Collaborative Group. Chemotherapy in non-small cell lung cancer: a meta-analysis using updated data on individual patients from 52 randomised clinical trials. *British Medical Journal* 1995;311:899-909.

Sarcoma Meta-analysis Collaboration. Adjuvant chemotherapy for localised resectable soft tissue sarcoma in adults: meta-analysis of individual patient data. *Lancet* 1997;350:1647-54.

Advanced Ovarian Cancer Trialists' Group. Chemotherapy in advanced ovarian cancer: four systematic meta-analyses of individual patient data from 37 randomized trials. *British Journal of Cancer* 1998;78:1479-87.

Arnott SJ, Duncan W, Gignoux M, David GJ, Hansen HS, Launois B, et al. Preoperative radiotherapy in esophageal carcinoma: a meta-analysis using individual patient data (Oesophageal Cancer Collaborative Group). *International Journal of Radiation Oncology Biology Physics* 1998;41:579-83.

PORT Meta-analysis Trialists Group. Postoperative radiotherapy in non-small-cell lung cancer: systematic review and meta-analysis of individual patient data from nine randomised controlled trials. *The Lancet* 1998;352:257-63.

Glioma Meta-analysis Trialists (GMT) Group. Chemotherapy in adult high-grade glioma: a systematic review and meta-analysis of individual patient data from 12 randomised trials. *Lancet* 2002;359:1011-8.

Advanced Bladder Cancer (ABC) Meta-analysis Collaboration. Neoadjuvant chemotherapy in invasive bladder cancer: a systematic review and meta-analysis. *Lancet* 2003;361:1927-34.

Neoadjuvant Chemotherapy for Cervical Cancer Meta-analysis Collaboration. Neoadjuvant chemotherapy for locally advanced cervical cancer: a systematic review and meta-analysis of individual patient data from 21 randomised trials. *European Journal of Cancer* 2003;39:2470-86.

#### Service de Biostatistique et d'Epidemiologie, Institut Gustave-Roussy, France

Pignon J-P, Arriagada R, Ihde DC, Johnson DH, Perry MC, Souhami RL, et al. A meta-analysis of thoracic radiotherapy for small-cell lung cancer. *New England Journal of Medicine* 1992;327:1618-24.

Non-small Cell Lung Cancer Collaborative Group. Chemotherapy in non-small cell lung cancer: a meta-analysis using updated data on individual patients from 52 randomised clinical trials. *British Medical Journal* 1995;311:899-909.



Aupérin A, Arriagada R, Pignon J-P, Le Péchoux C, Gregor A, Stephens RJ, et al. Prophylactic cranial irradiation for patients with small-cell lung cancer in complete remission. *The New England Journal of Medicine* 1999;341: 476-484.

Pignon JP, Bourhis J, Domenge C, Designé L, on behalf of the MACH-NC Collaborative Group. Chemotherapy added to locoregional treatment for head and neck squamous cell carcinoma: three meta-analyses of updated individual data. *Lancet* 2000;355:949-55.

Bourhis J, Syz N, Overgaard J, Ang KK, Dische S, Horiot J, et al. Conventional vs modified fractionated radiotherapy. Meta-analysis of radiotherapy in head & neck carcinoma: a meta-analysis based on individual patient data. *International Journal of Radiation Oncology Biology Physics* 2002;54(Suppl):71-2.

Piedbois P, Michiels S for the Meta-analysis Group in Cancer. Survival benefit of 5FU/LV over 5FU bolus in patients with advanced colorectal cancer: an updated meta-analysis based on 2751 patients. *Proceedings of the American Society of Clinical Oncology* 2003;22:294.

Auperin A, Le Pechoux C on behalf of the MAC3-LG Group. Meta-analysis of randomized trials evaluating cisplatin or carboplatin-based concomitant chemoradiation versus radiotherapy alone in locally advanced non-small cell lung cancer (NSCLC). *Lung Cancer* 2003;41(Suppl 2):S69.