Improving a safety of the Continual Reassessment Method via a modified allocation rule

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Motivation

Consider a Phase I clinical trial with binary responses and two doses: d_1, d_2

Goal is to find the maximum tolerated dose (MTD): $\gamma = 0.30$.

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It is usually of interest to balance two aims in a Phase I clinical trial

Current solutions

Safety:

Escalation with Overdose Control (EWOC) design by Babb et al. (1998):

$$\mathbb{E}\left(\alpha(\gamma - P_i)^+ + (1-\alpha)(P_i - \gamma)^+\right) \tag{2}$$

+ Low average number of DLTs
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Safety & Uncertainty

Bayesian Logistic Regression Model (BLRM) by Neuenschwander et al. (2008). uses the whole distribution of the DLT probability and penalties for overly toxic intervals. For example, for $\gamma = 0.33$

$$L = \begin{cases} 1 \text{ if } p \in (0.00, 0.26); & 0 \text{ if } p \in (0.26, 0.41); \\ 1 \text{ if } p \in (0.41, 0.66); & 2 \text{ if } p \in (0.66, 1.00) \end{cases}$$

Goal

We propose a new criterion for selecting doses in dose-escalation trials that accounts for

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We incorporate the proposed criterion to the one-parameter Bayesian continual reassessment method (O'Quigley et al., 1990, CRM)

Novel Criterion

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$$\delta(p, \gamma) = \frac{(p - \gamma)^2}{p(1 - p)}. \tag{3}$$

- $\delta(\cdot) = 0$ at $p = \gamma$
- $\delta(\cdot) \to \infty$ as $p \to 0$ or $p \to 1$
- The variance in denominator (Criterion 3 is a score statistic)

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In the illustration example above

$$\delta(\hat{p}_1 = 0.2, \gamma = 0.3) = 1/16 \quad \text{and} \quad \delta(\hat{p}_2 = 0.4, \gamma = 0.3) = 1/24$$

(!) Single point estimate summarizes the information about uncertainty.

Introducing safety compound

The target toxicity γ is always less than 0.5.

Then for estimates $\hat{p}_1 = \gamma - \theta$ and $\hat{p}_2 = \gamma + \theta$, symmetric criterion favours $\hat{p}_2$.

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We introduce an asymmetry parameter a:

$$\delta(p, \gamma) = \frac{(p - \gamma)^2}{p^a (1 - p)^{2-a}}. \tag{4}$$

$0 < a < 1$ implies more severe penalty for more toxic doses.

(!) Selection of under toxic doses remain to be undesirable as well.

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In the illustration example above, for $a = 0.5$

$$\delta(\hat{p}_1 = 0.2, \gamma = 0.3, a = 0.5) < \delta(\hat{p}_2 = 0.4, \gamma = 0.3, a = 0.5).$$

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Parameter *a* balances the trade-off between ethical concerns and uncertainty

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$a < 2\gamma$ leads to more conservative allocation of patients.

Let $(\gamma - \theta, \gamma + \theta)$ be an interval such that among two estimates standing on the same squared distance from γ, the lower estimate would be preferred

$$a = 2 \times \left(1 + \left(\log \frac{\gamma - \theta}{\gamma + \theta}\right) / \left(\log \frac{1 - \gamma - \theta}{1 - \gamma + \theta}\right)\right)^{-1}$$

Bayesian continual reassessment method

DLT probability has the functional form $\psi(d_i, \beta) = d_i^{\exp(\beta)}$.

$f_0(.)$ is prior distribution of β. After j patients have already been assigned to doses $d(1), \ldots, d(j)$ and binary responses $\mathbb{Y}_j = [y_1, \ldots, y_j]^{\mathrm{T}}$ were observed the posterior $f_j(\beta)$ is obtained.

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Then, the dose d_k minimising

$$\mathbb{E}\left(\frac{(\psi(d_i, \beta) - \gamma)^2}{\psi(d_i, \beta)^a (1 - \psi(d_i, \beta))^{2-a}}\right) \tag{5}$$

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Convex Infinite Bounds Penalization with parameter a as CIBP(a).

Illustration (I)

We revisit the Everolimus Trial in patients with HER2-overexpressing Metastatic Breast Cancer $\gamma = 0.3$. The study considers 3 regimens given together with Paclitaxel and Trastuzumab (PT):

1. Daily dosing of Everolimus 5mg plus PT (d_1)
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Table : Aggregated data of the Everolimus trial

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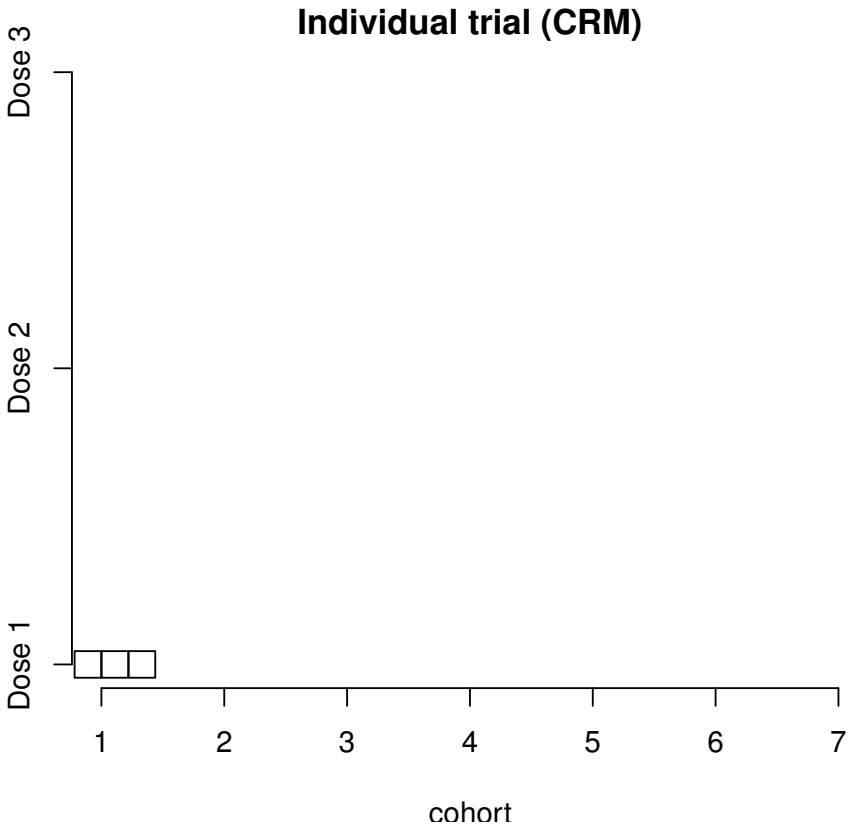
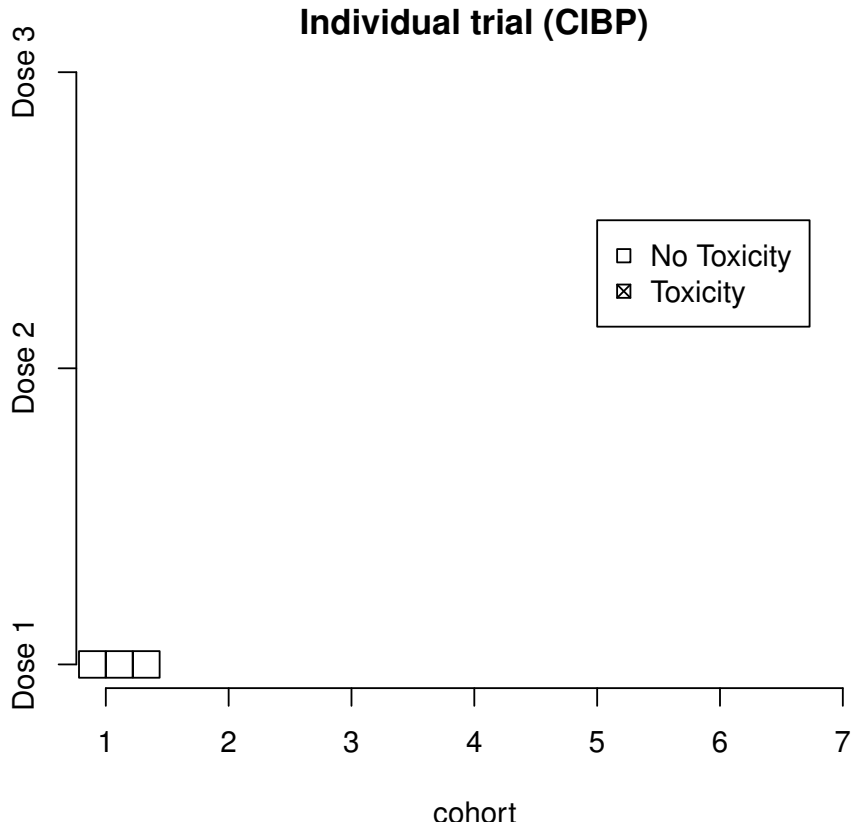
We compare original CRM and CIBP (0.3) using the same prior parameters.

Illustration (II)





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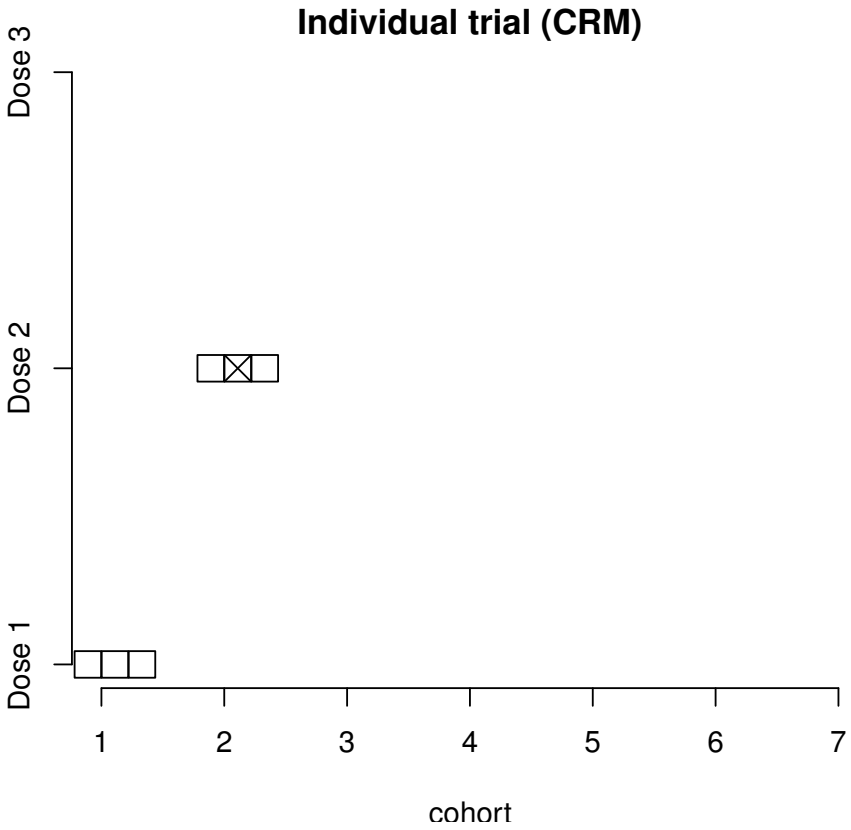

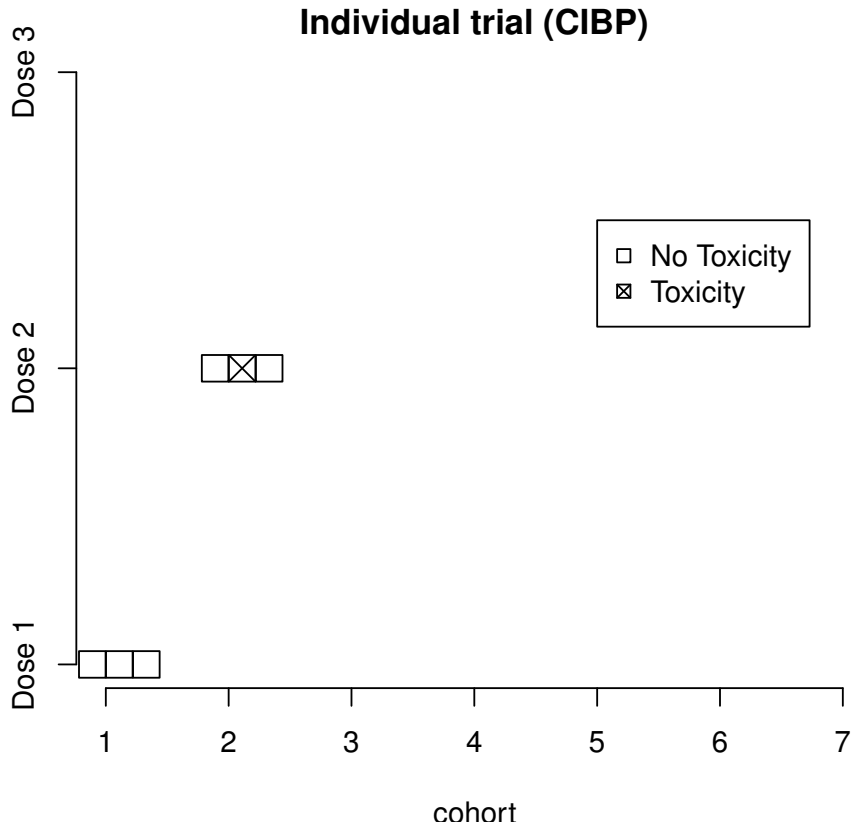

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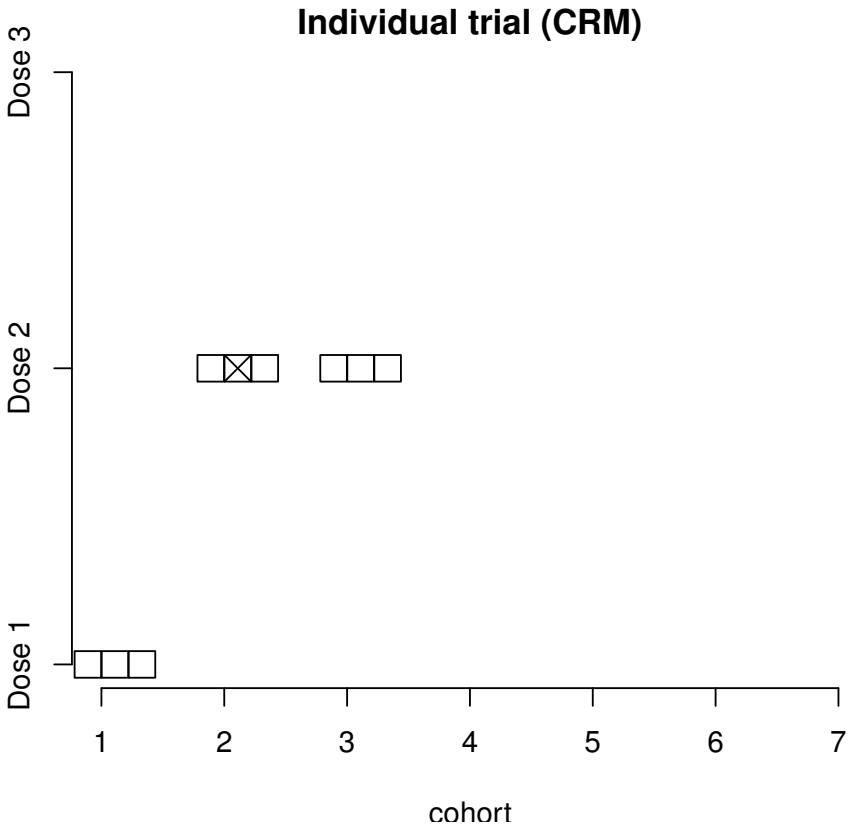

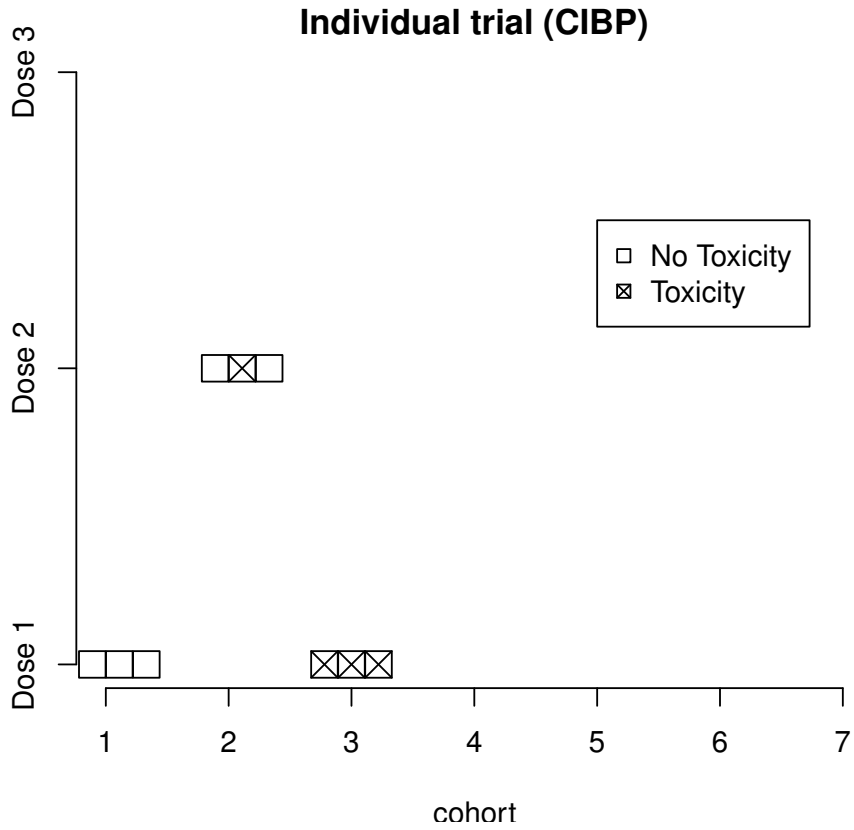

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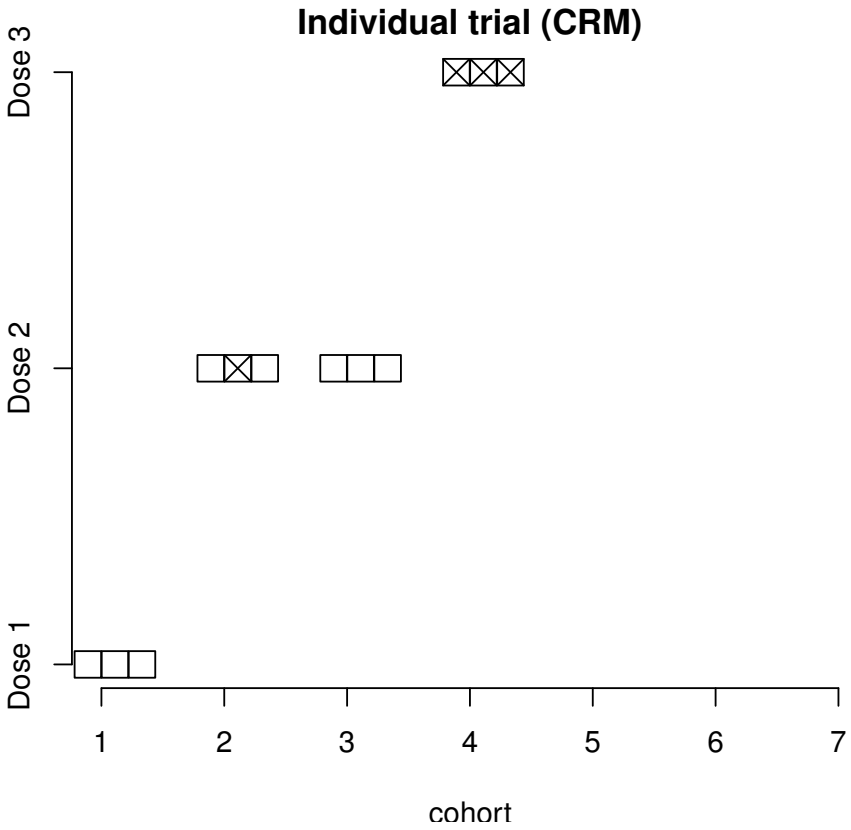

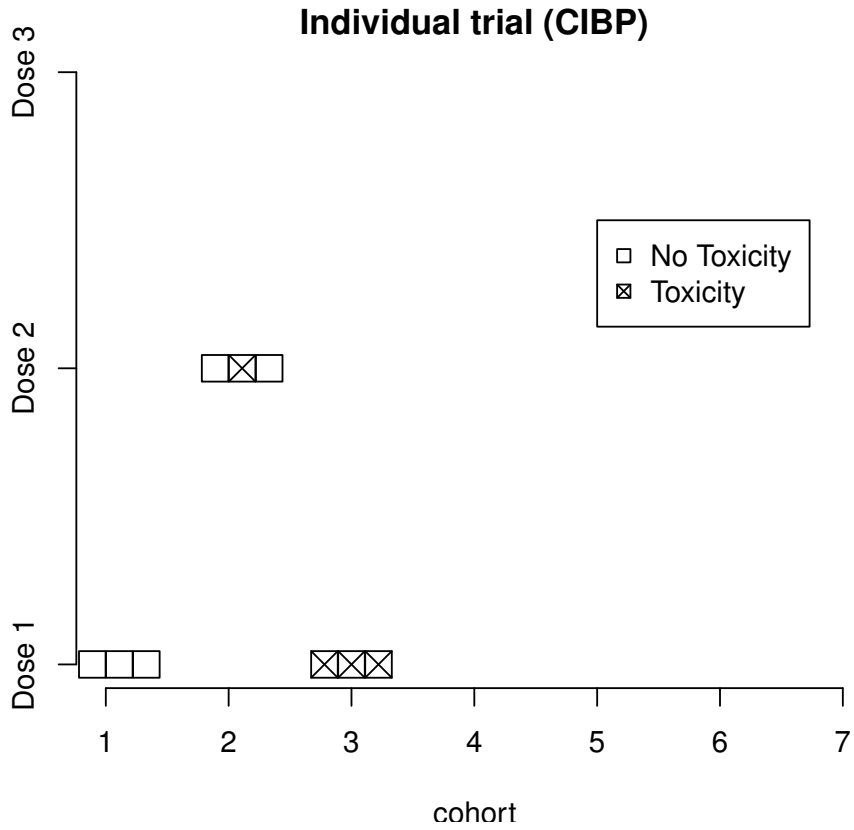

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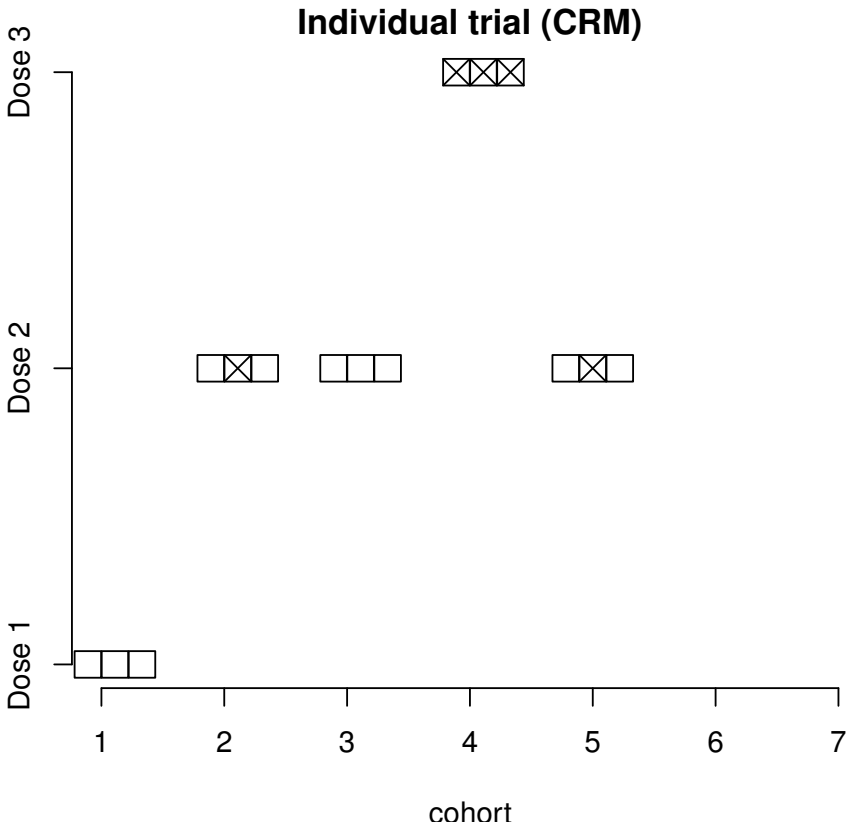

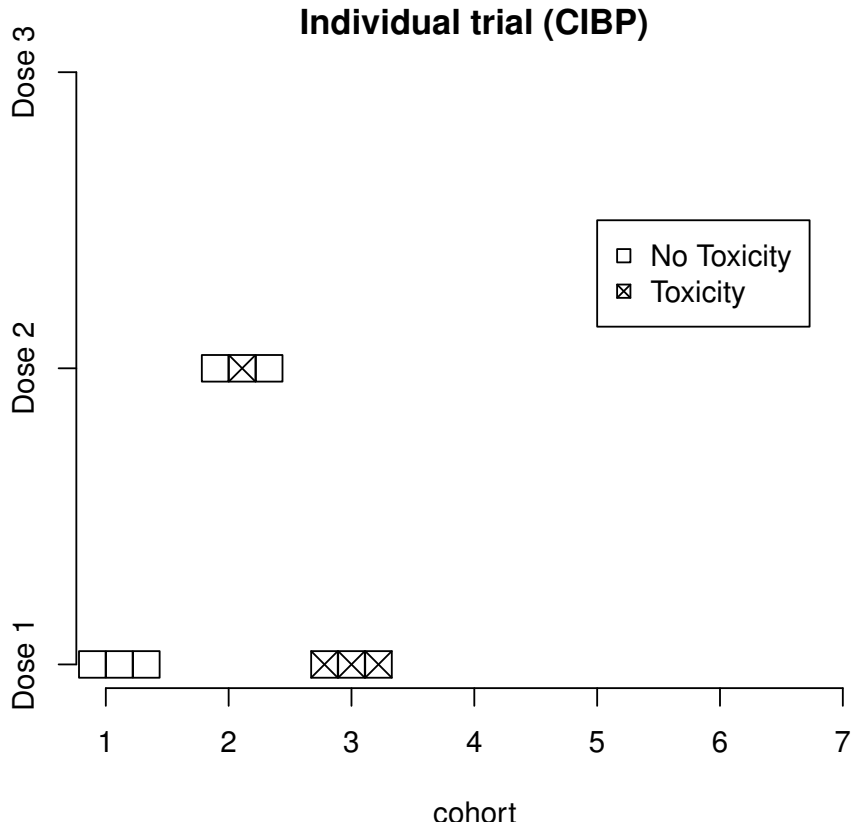

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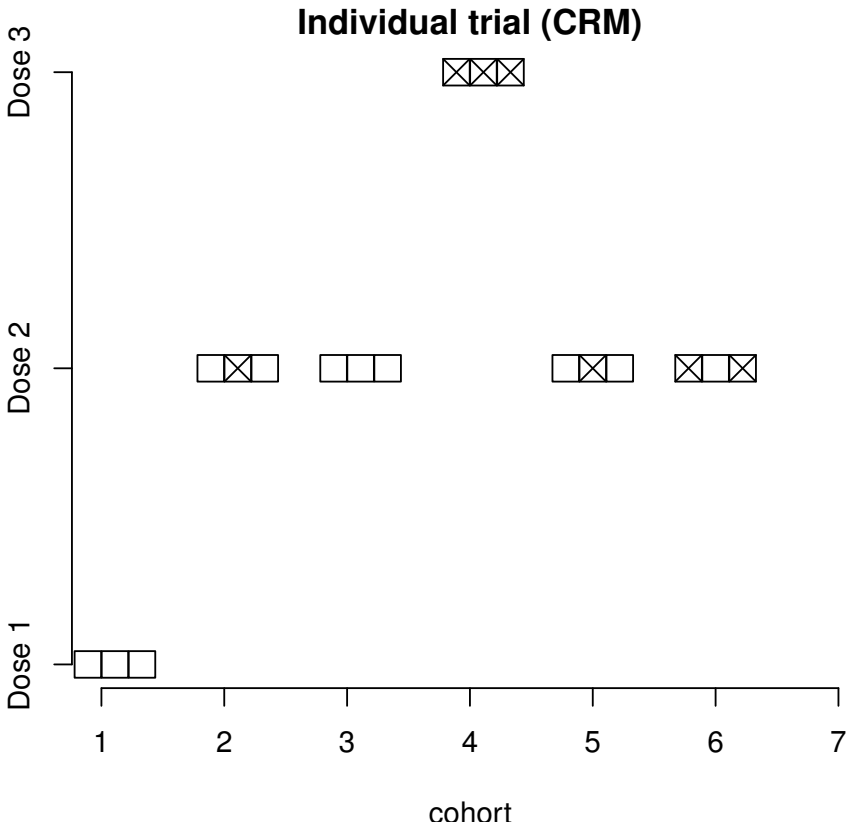

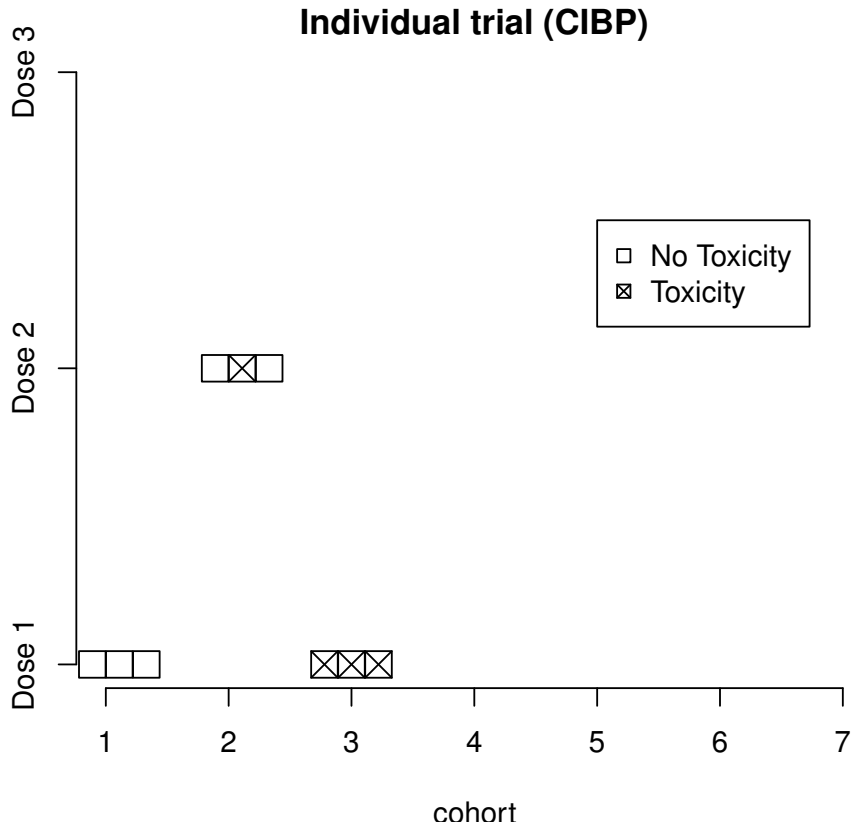

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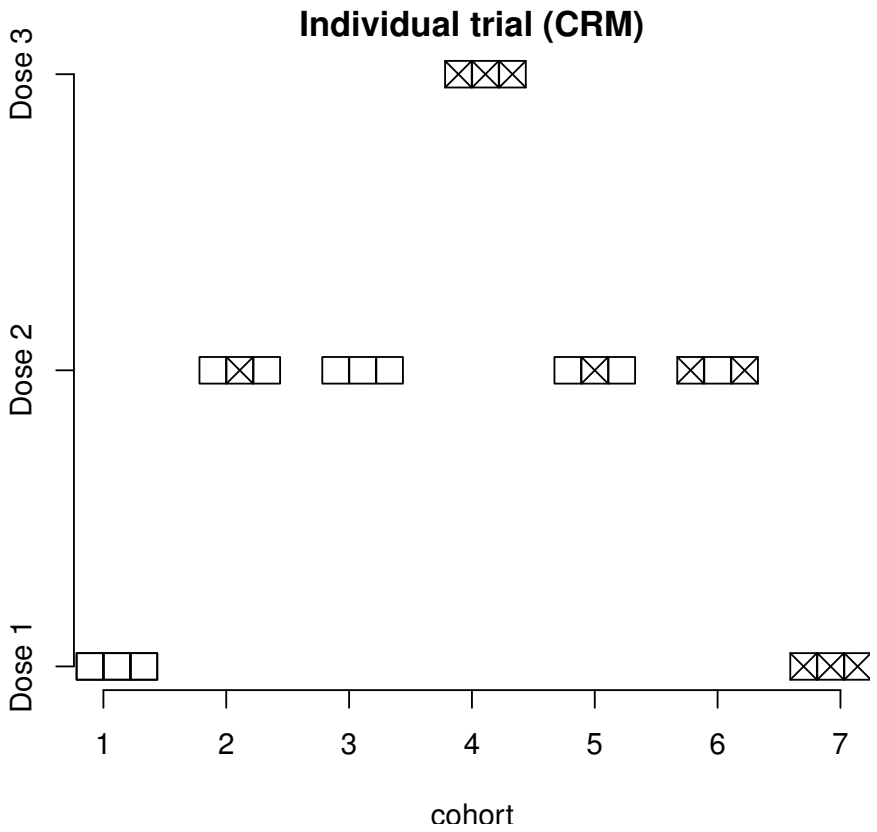

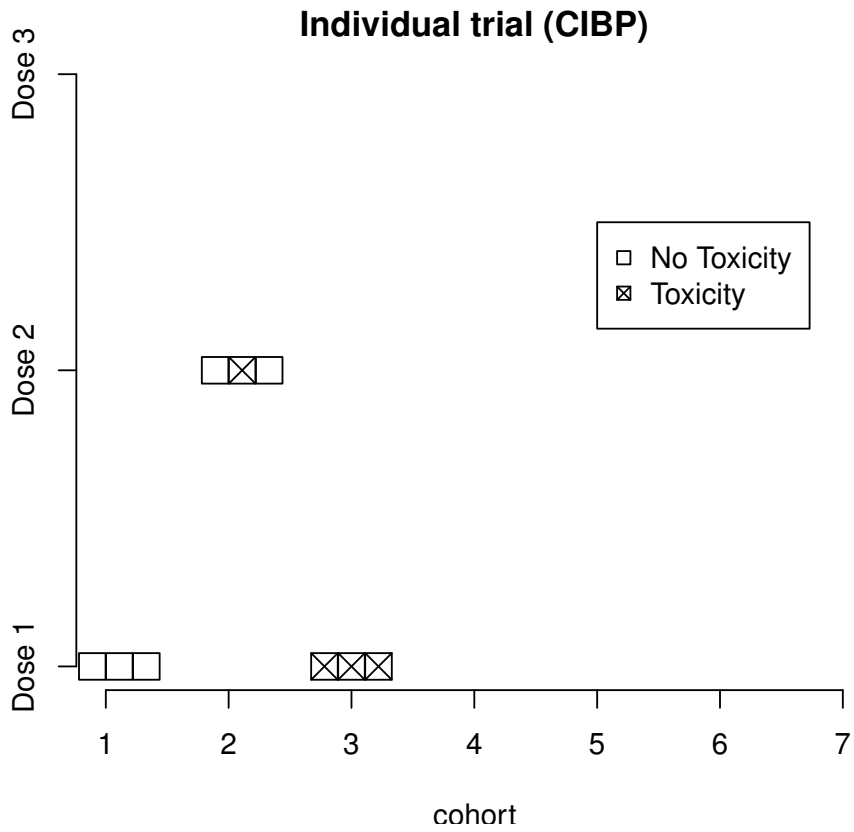

Numerical Study

Setting by Wheeler et al. (2017).

- $n = 40$ patients; $m = 6$ doses; $c = 1$ cohort size; target $\gamma = 0.33$
- $\beta \sim \mathcal{N}(0, 1.34)$
- $a = \{0.5, 0.25, 0.10\}$.

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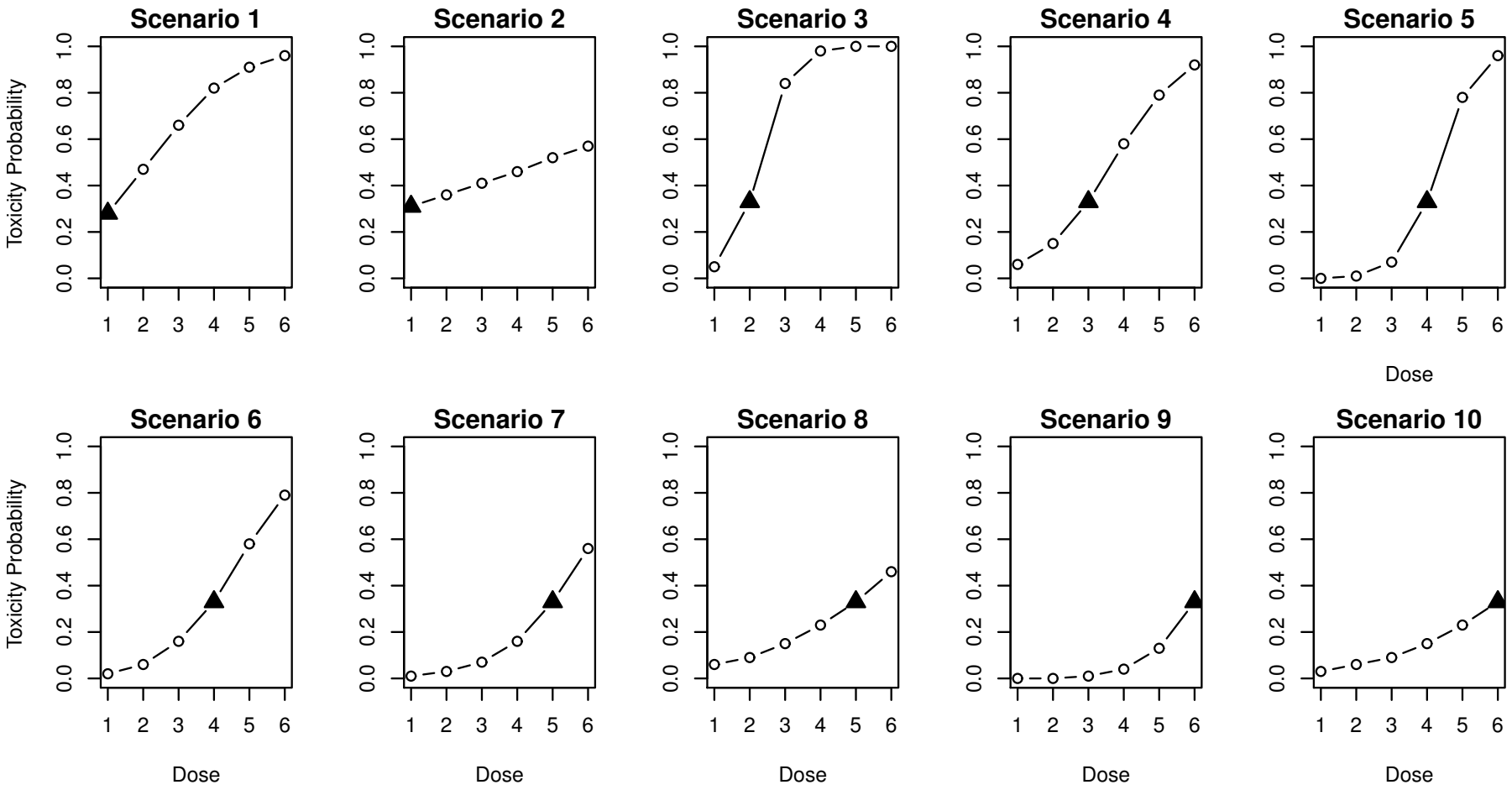
We study the performance of designs in terms of
(i) *Accuracy*

$$\mathcal{A} = 1 - m\frac{\sum_{i=1}^{m}(p_i - \gamma)^2 \pi_i}{\sum_{i=1}^{m}(p_i - \gamma)^2}$$

(*ii*) mean number of toxic responses (DLTs) and focus on the mean performance.

Scenarios


Scenario 1
Scenario 2
Scenario 3
Scenario 4
Scenario 5
Scenario 6
Scenario 7
Scenario 8
Scenario 9
Scenario 10
Toxicity Probability
Dose
0.0
0.2
0.4
0.6
0.8
1.0
1
2
3
4
5
6

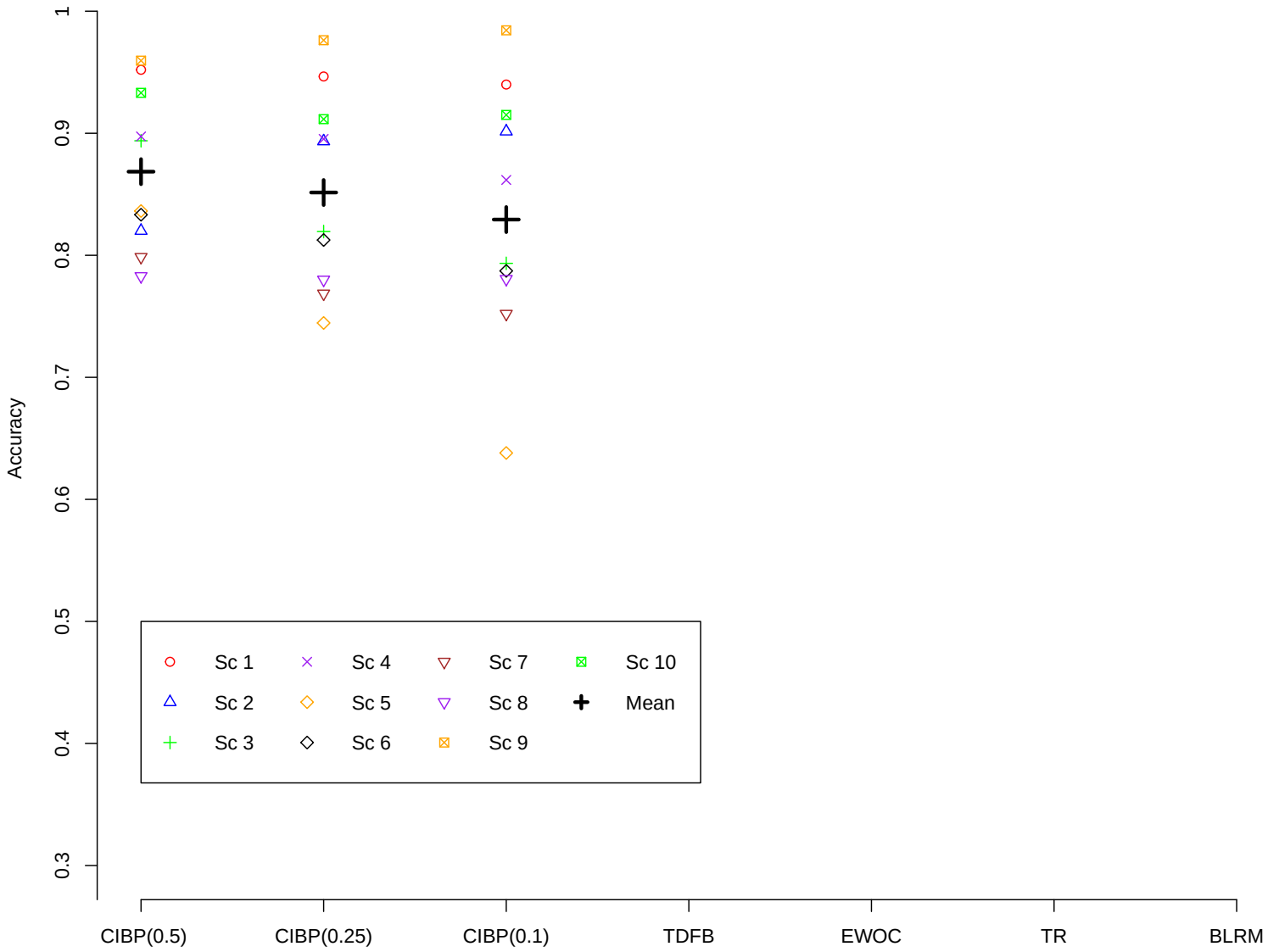
Comparators

We compare the performance of the proposed approach to

- **EWOC**
- **TR** design by Tighiouart et al. (2010)
- Toxicity-dependent feasibility bound (**TDFB**) by Wheeler et al. (2017)
- **BLRM** by Neuenschwander et al. (2008)

We use the same prior distribution as Neuenschwander et al. (2008).

Results. Accuracy



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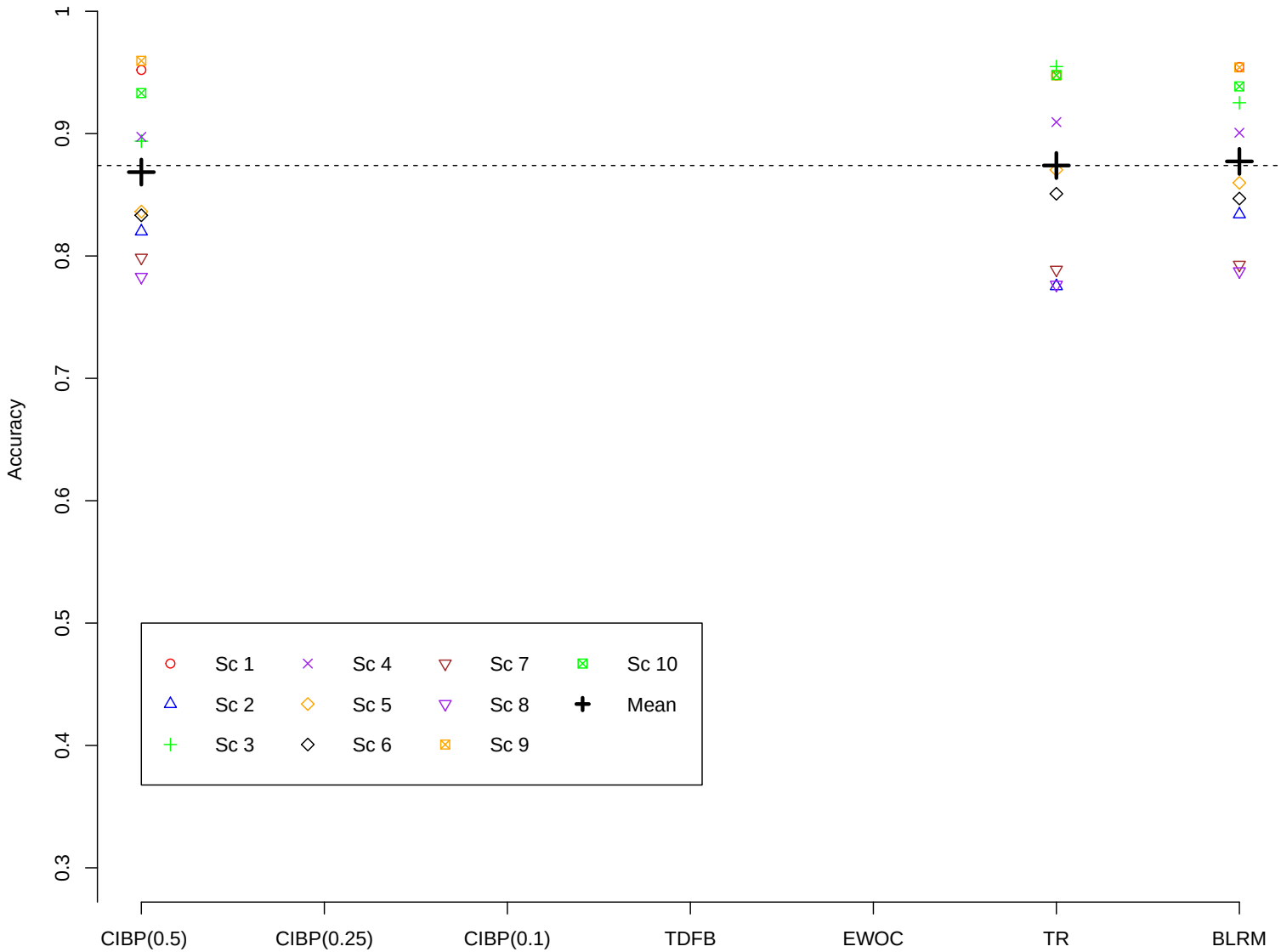

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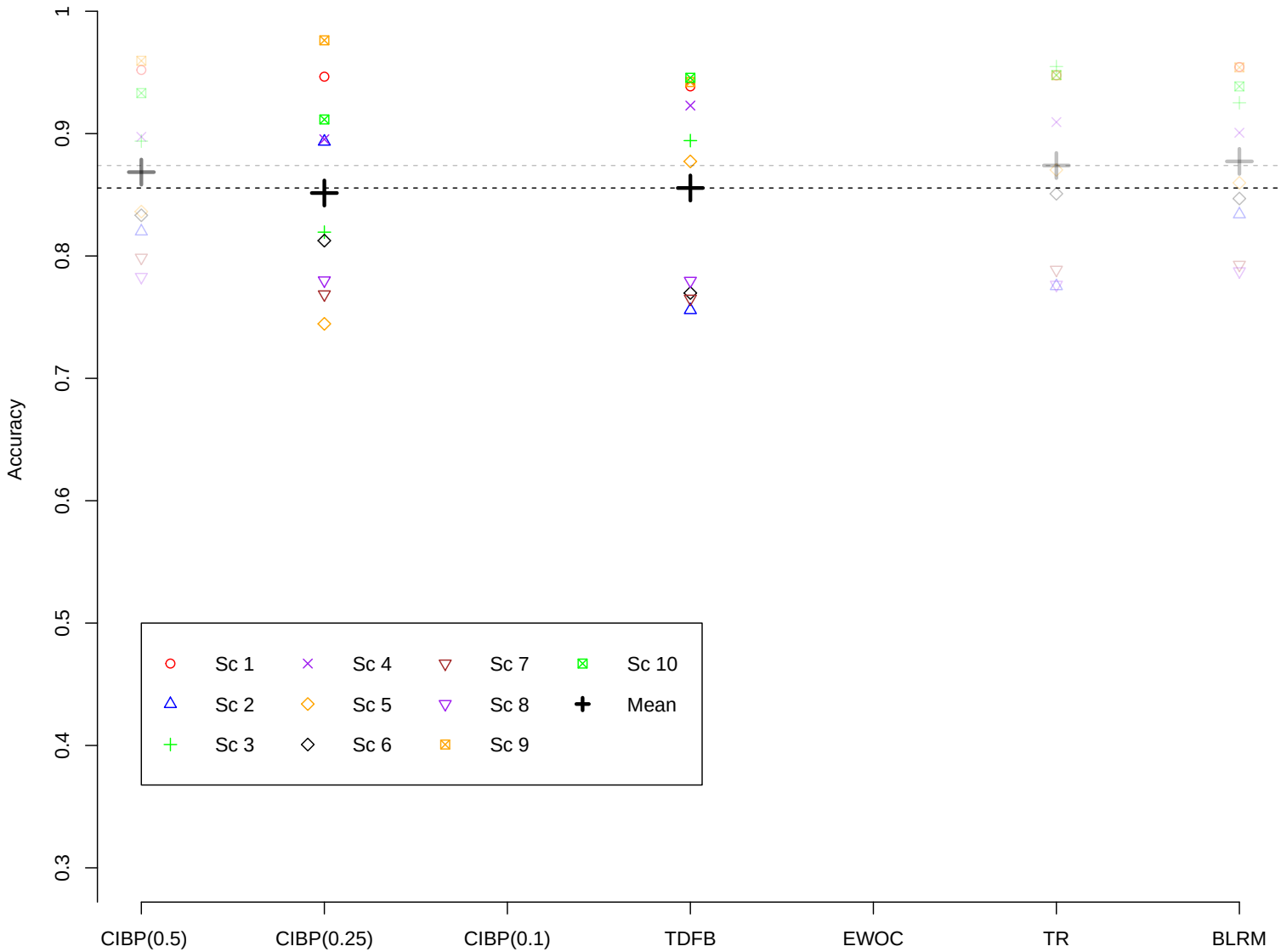

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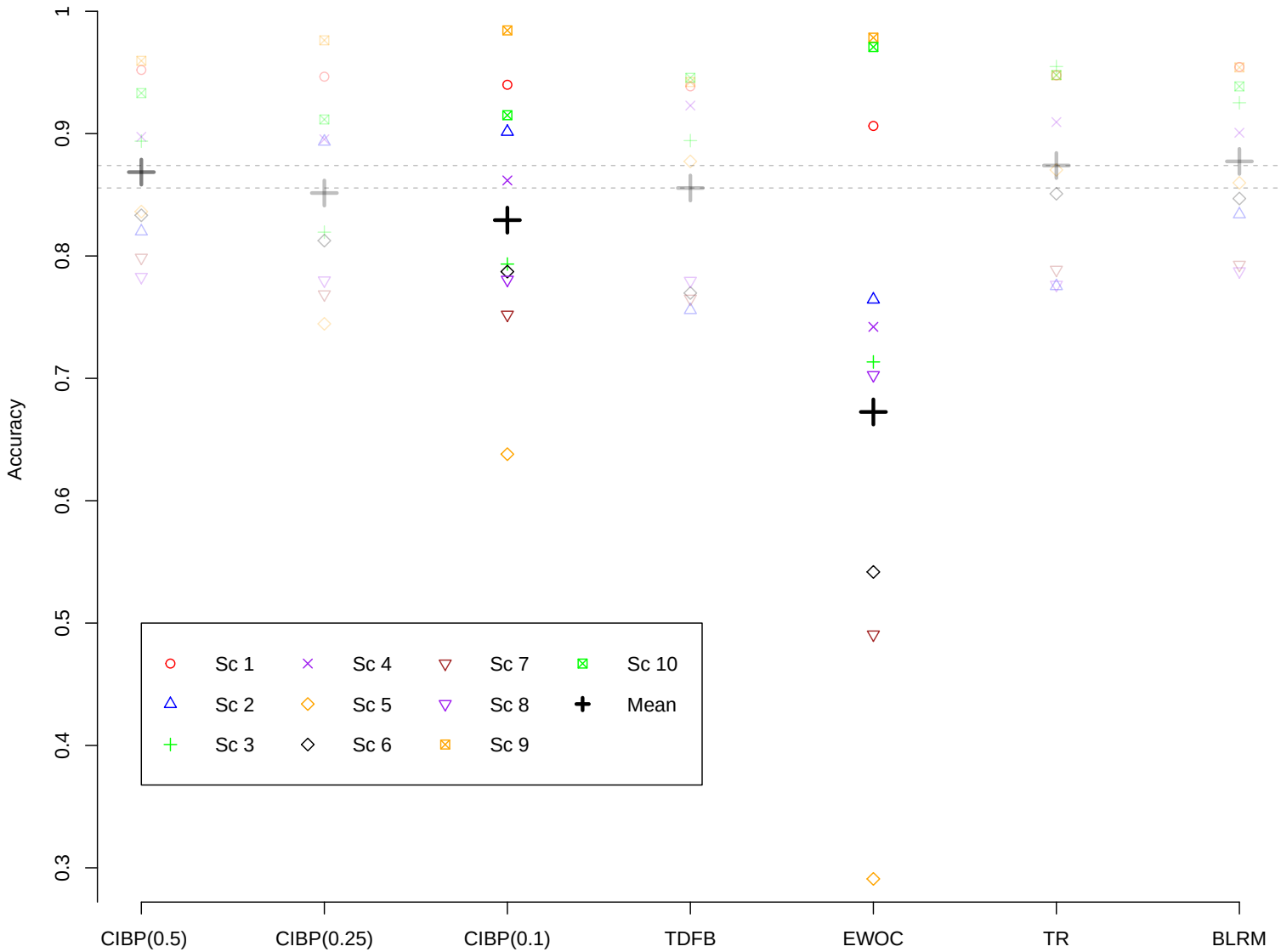
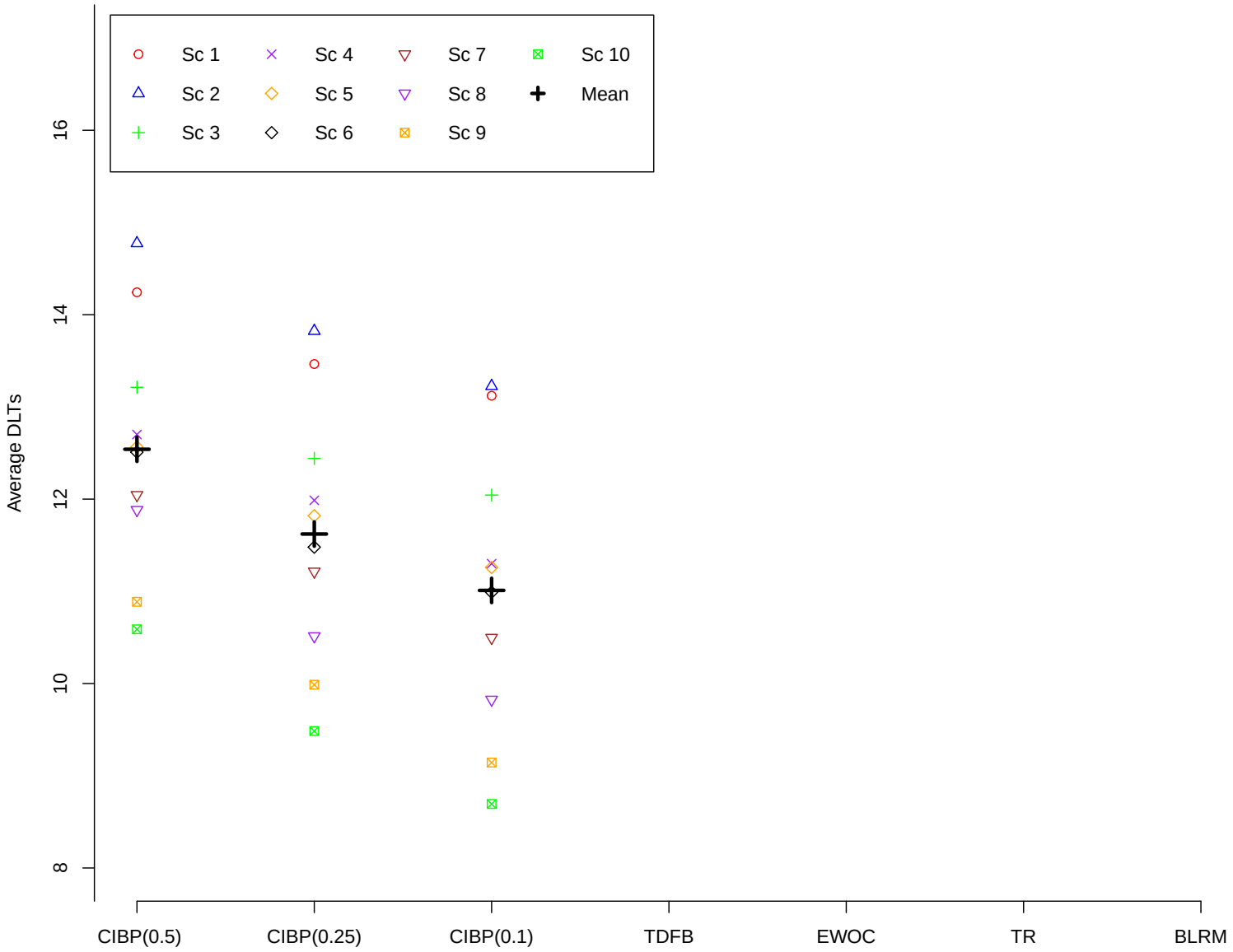


Results.DLTs



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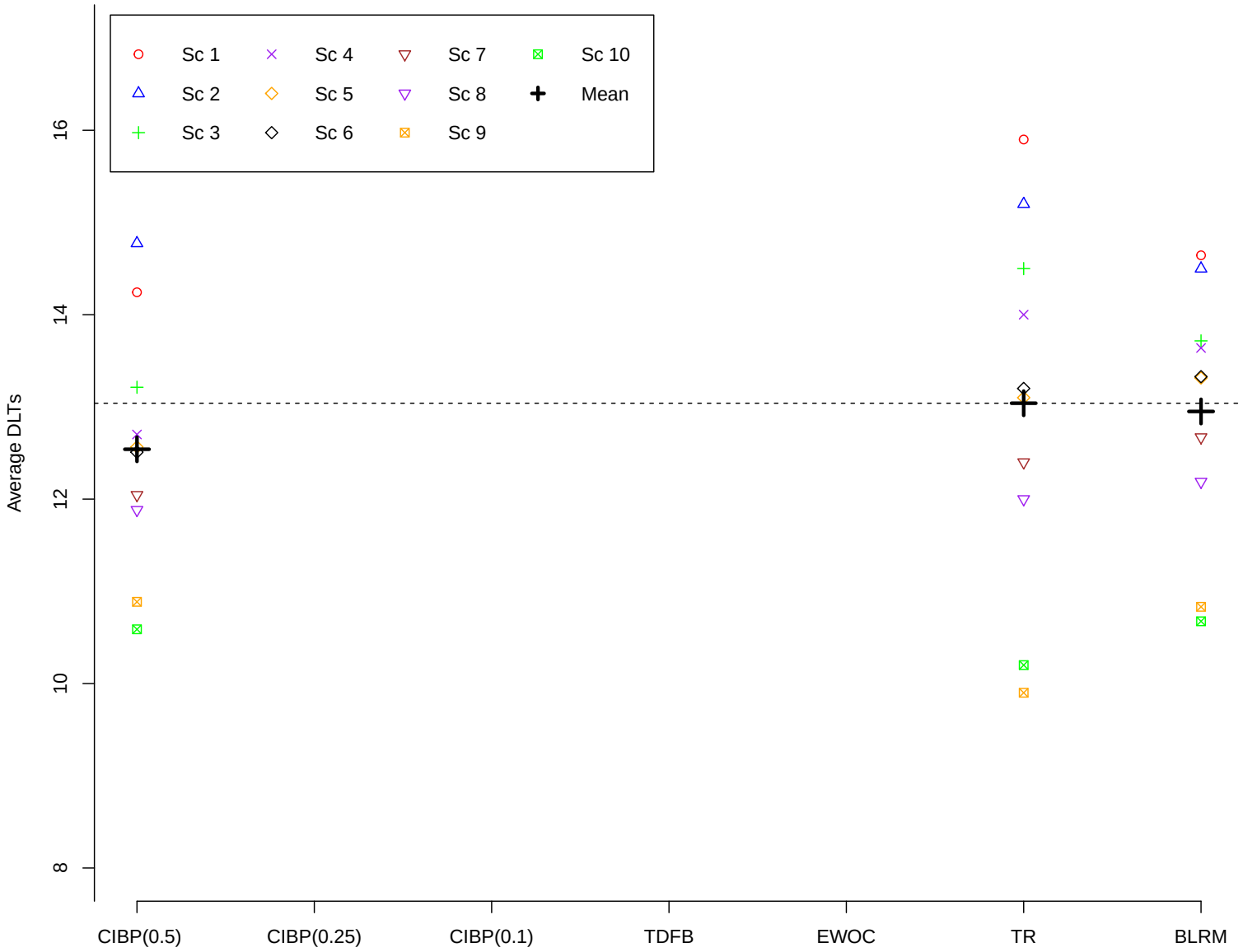

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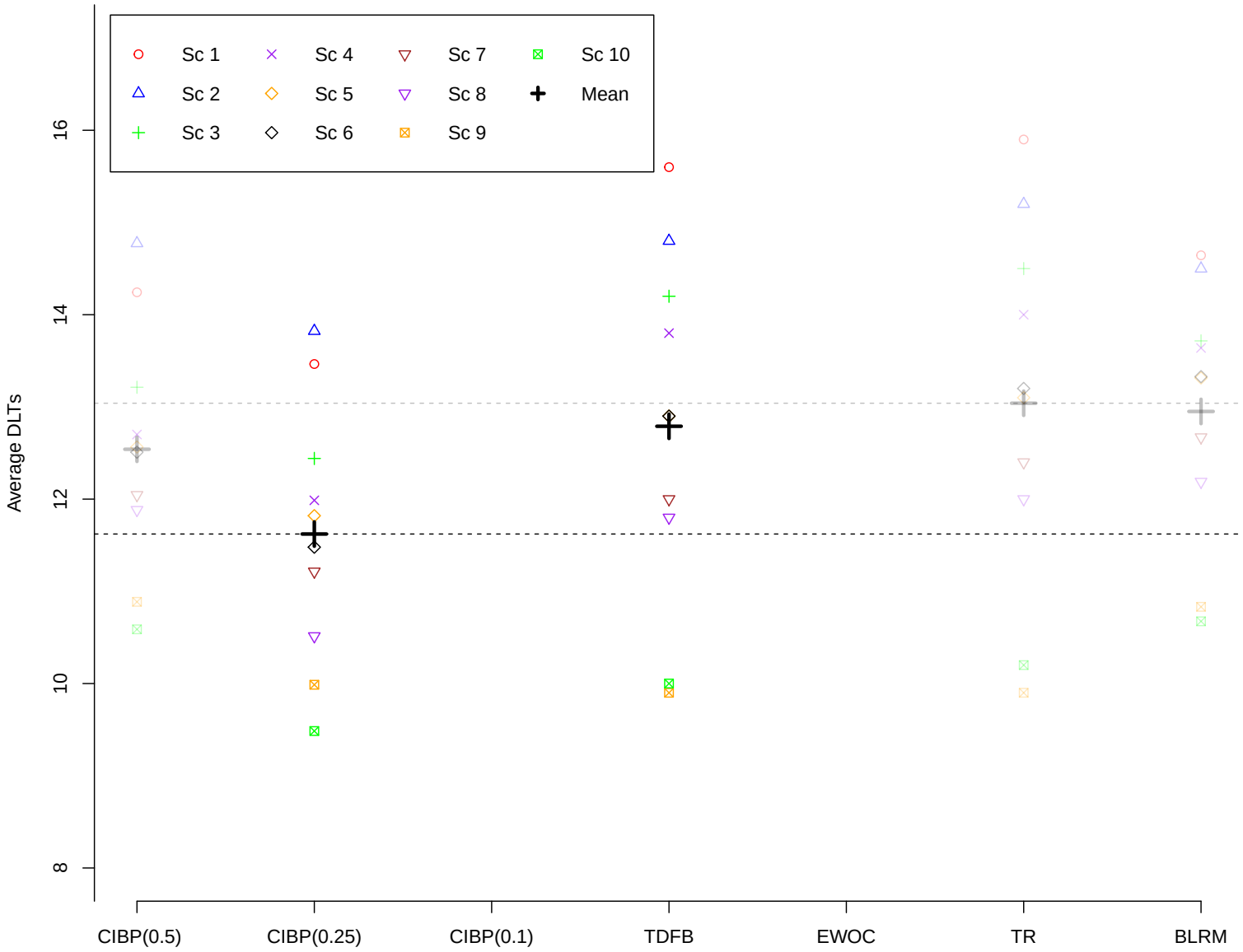

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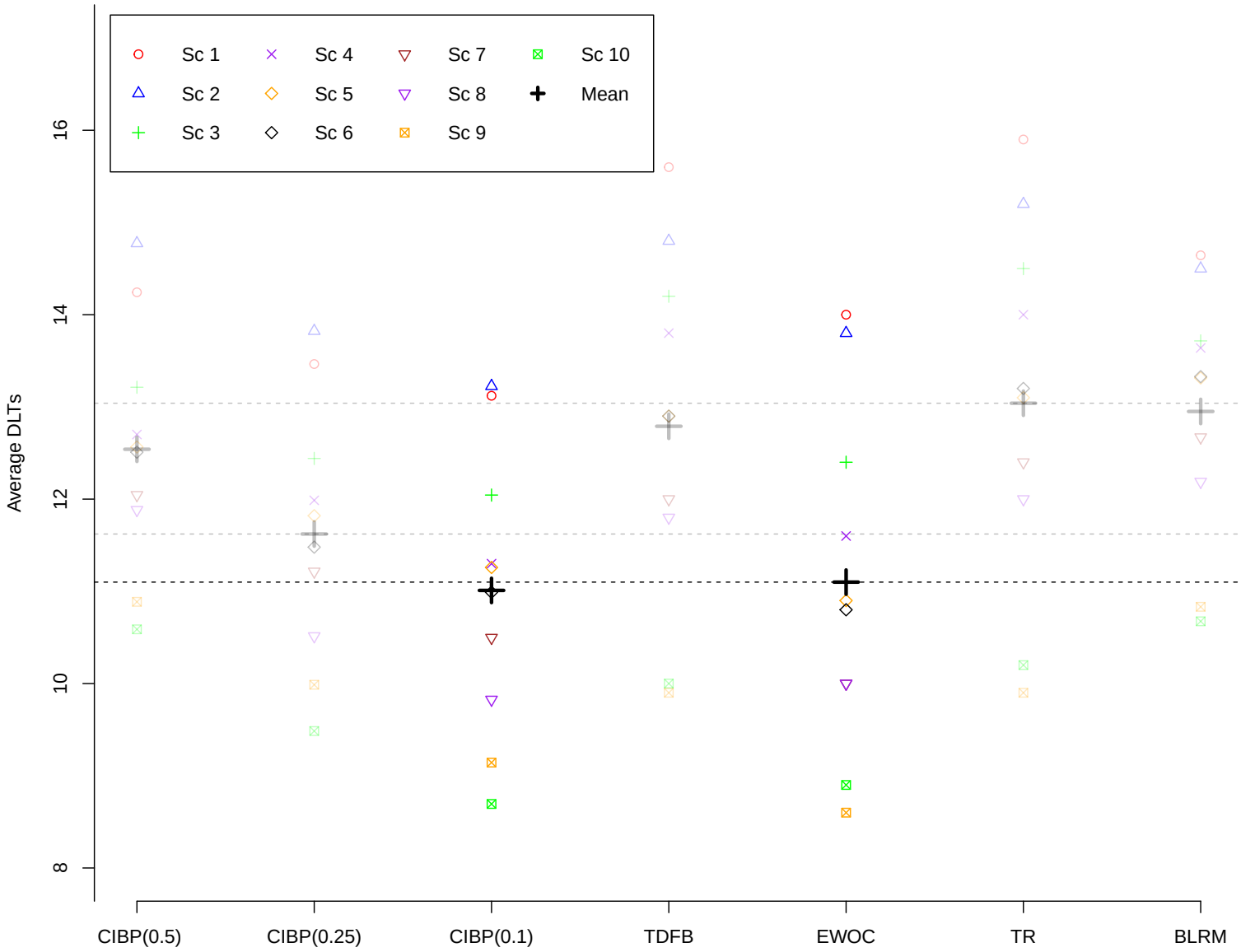


Conclusions

The novel criterion requires **one additional parameter only**.
The criterion incorporated into the one-parameter CRM method is found to result in

1. **Similar** accuracy, but **fewer** mean number of DLTS.
2. **Greater** accuracy, but **similar** mean number of DLTs.

(!) The new criterion allows to make model-based design **more ethical** as it does not lead to any decrease in accuracy.

Further work:
Generalisation to dose-combination and dose-schedule trials including the case of delayed toxicity responses.

Aitchison, J. (1992) On criteria for measures of compositional difference. *Mathematical Geology*, **24**, 365–379.

Babb, J., Rogatko, A. and Zacks, S. (1998) Cancer phase I clinical trials: efficient dose escalation with overdose control. *Statistics in medicine*, **17**, 1103–1120.

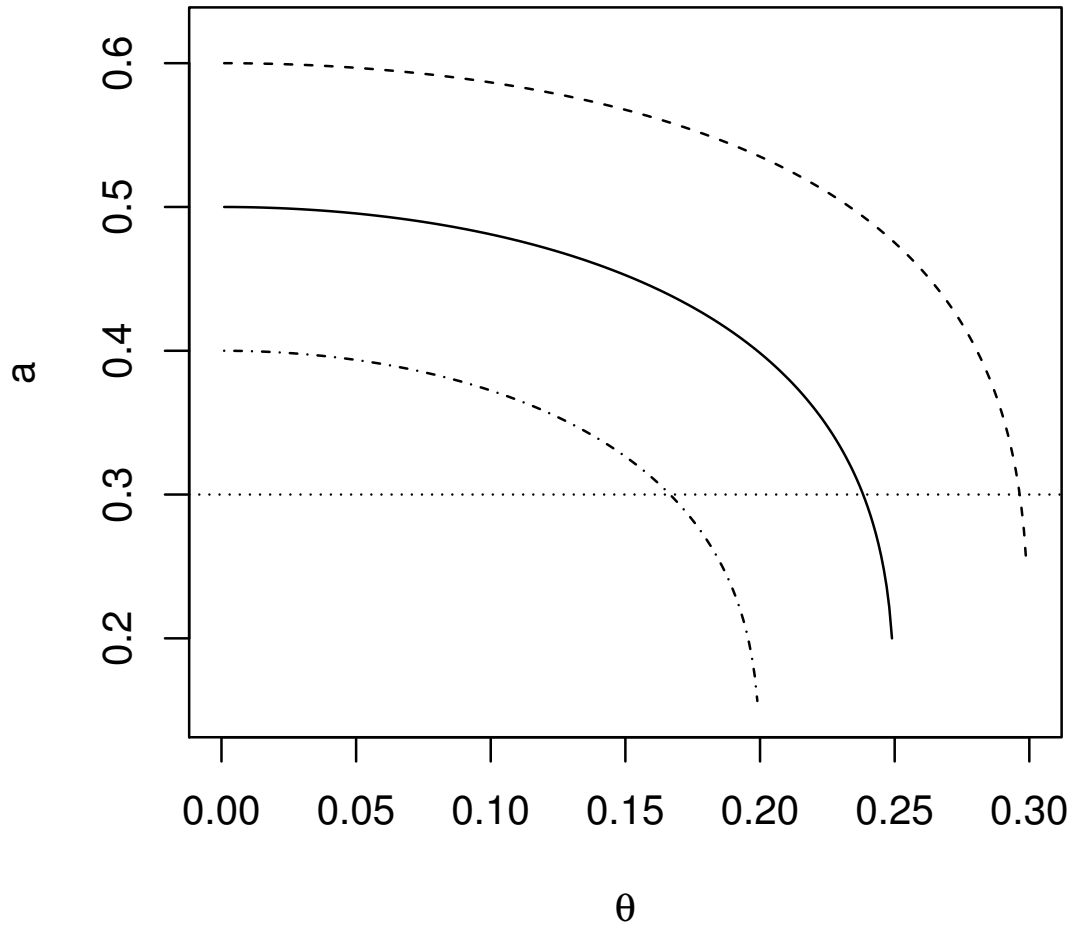
Neuenschwander, B., Branson, M. and Gsponer, T. (2008) Critical aspects of the Bayesian approach to phase I cancer trials. *Statistics in Medicine*, **27**, 2420–2439.

O'Quigley, J., Pepe, M. and Fisher, L. (1990) Continual reassessment method: a practical design for phase 1 clinical trials in cancer. *Biometrics*, 33–48.

Tighiouart, M., Rogatko, A. et al. (2010) Dose finding with escalation with overdose control (ewoc) in cancer clinical trials. *Statistical Science*, **25**, 217–226.

Wheeler, G. M., Sweeting, M. J. and Mander, A. P. (2017) Toxicity-dependent feasibility bounds for the escalation with overdose control approach in phase i cancer trials. *Statistics in Medicine*.

Asymmetry parameter (II)



Comparators

We compare the performance of the proposed approach to

- **EWOC** design using fixed $\alpha = 0.25$
- **TR** design by Tighiouart et al. (2010) using $\alpha_2 = \ldots = \alpha_9 = 0.25$, $\alpha_n = \min(\alpha_{n-1} + 0.05, 0.50)$.
- Toxicity-dependent feasibility bound (**TDFB**) by Wheeler et al. (2017)

$$\alpha_{n+1} = \min\left(0.50, 0.25 + (0.50 - 0.25\frac{n - 1 - \sum_{i=1}^{n} y_i}{12\frac{2}{3}}\right)$$

- **BLRM** by Neuenschwander et al. (2008)
  We use the same prior distribution as Neuenschwander et al. (2008).