

# Efficient design and analysis of clinical value for paired medical tests at single and serial time points

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# Medical testing for screening and diagnostics

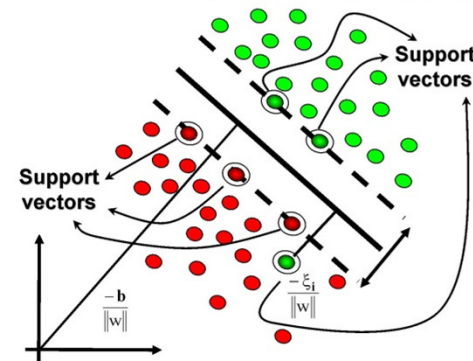
- Biomarkers



- Genetics



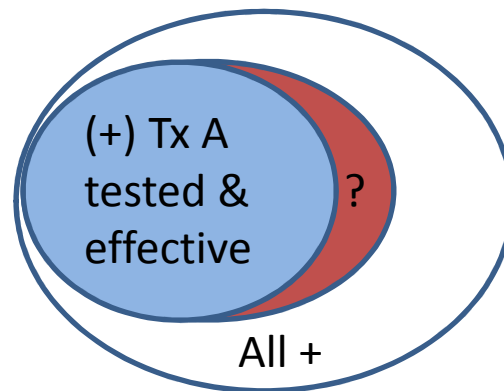
- Imaging



- Computational modeling

Why are these not used more in practice?

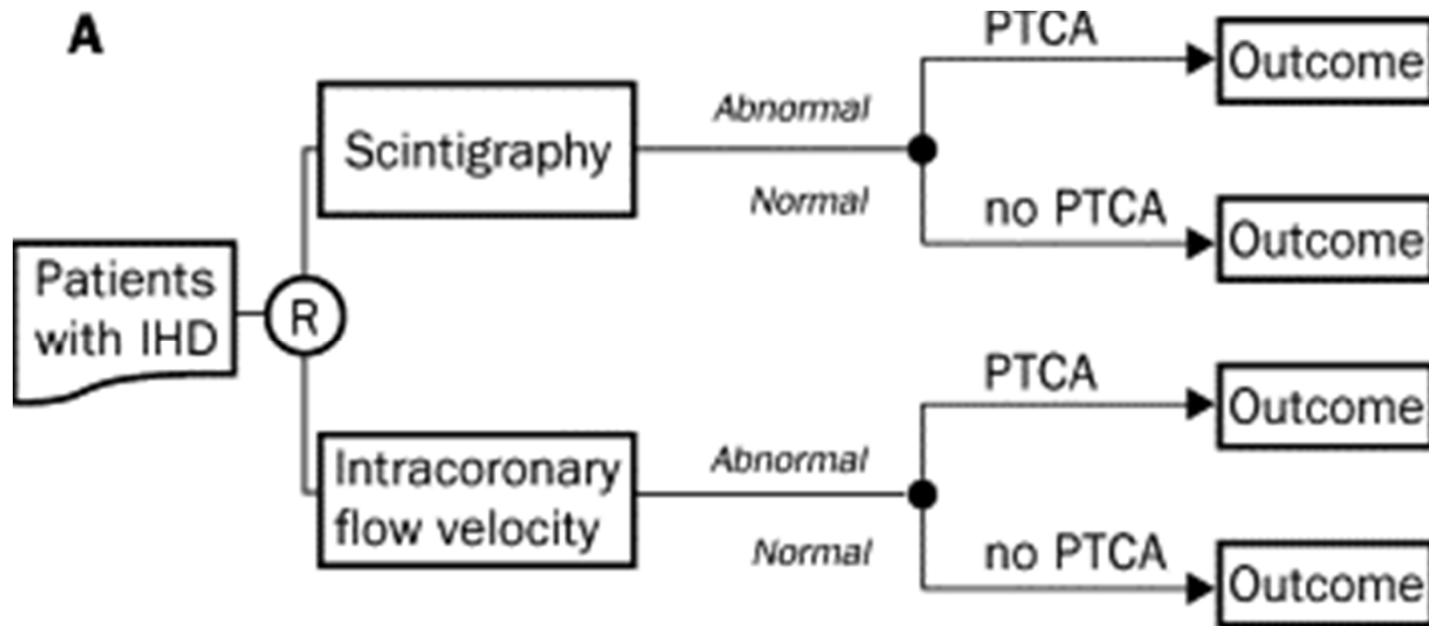
# Why do we need a RCT if a new medical test has higher accuracy?



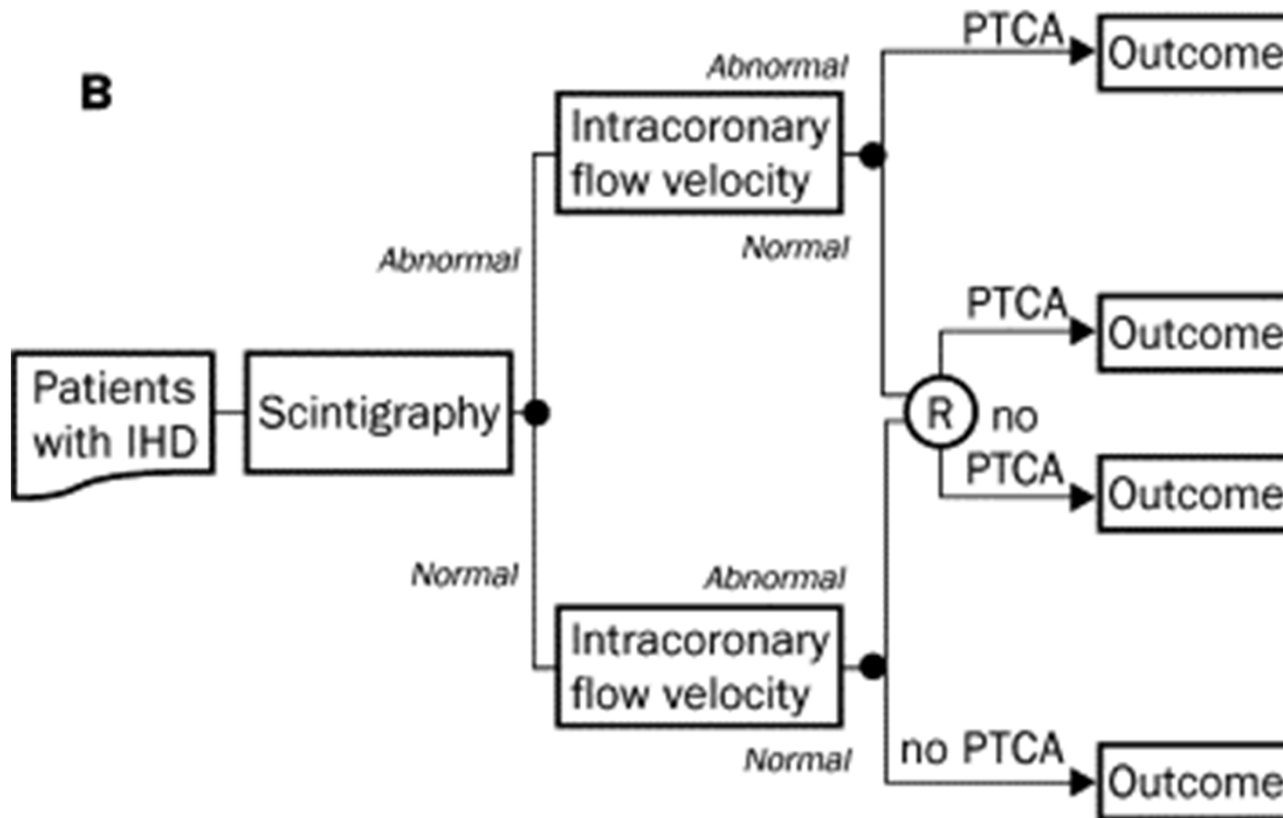
## Do we have efficacious treatment for these new correctly diagnosed patients?

Question: Which medical test has better clinical value?

# Randomized Clinical Trials Comparing Two Medical Tests

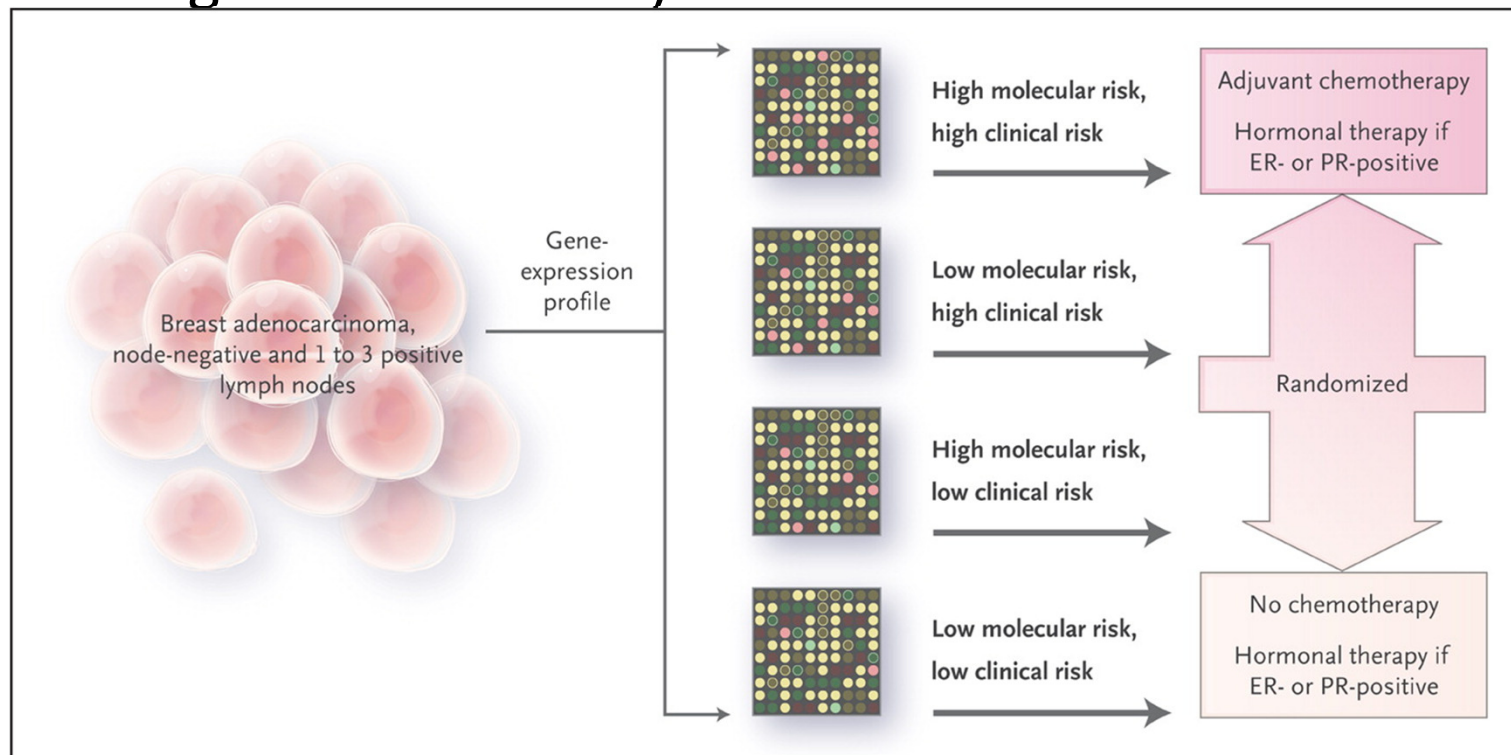


# Randomized Clinical Trials Comparing Two Medical Tests



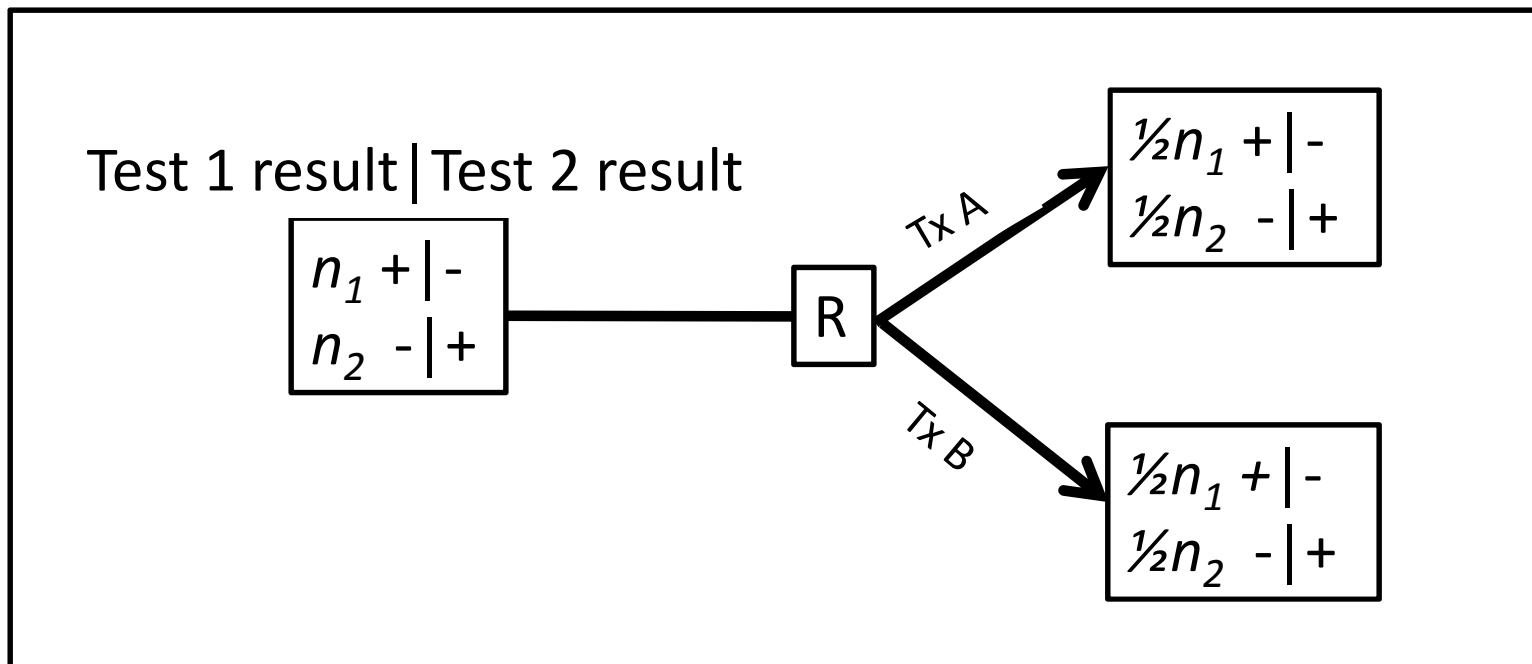
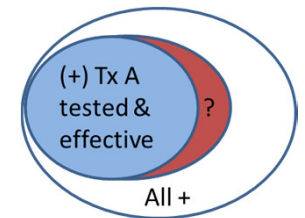
# Examples

- MINDACT (Microarray in Node Negative and 1 to 3 Positive Lymph Node Disease May Avoid Chemotherapy Trial)
  - RCT for Mammaprint (70 gene sig for relapse in early stage breast cancer)



# RCT setup

- Medical test 1, Medical Test 2
- (+) → Tx A, (-) → Tx B
  - Tx A was tested on the currently identifiable (+) patients
- Assumptions: no gold standard, order medical test irrelevant
- Outcome (binary): 5 year survival

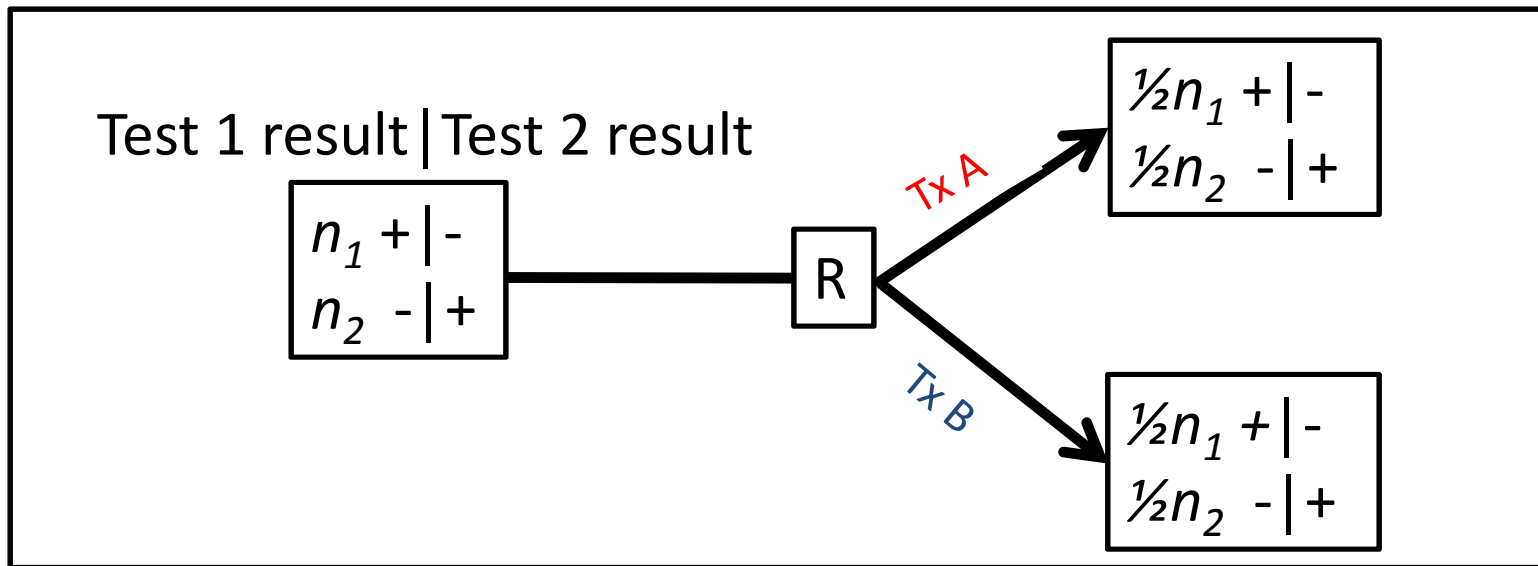




# 1. Statistical Analysis: Treatment

## Tx A versus Tx B

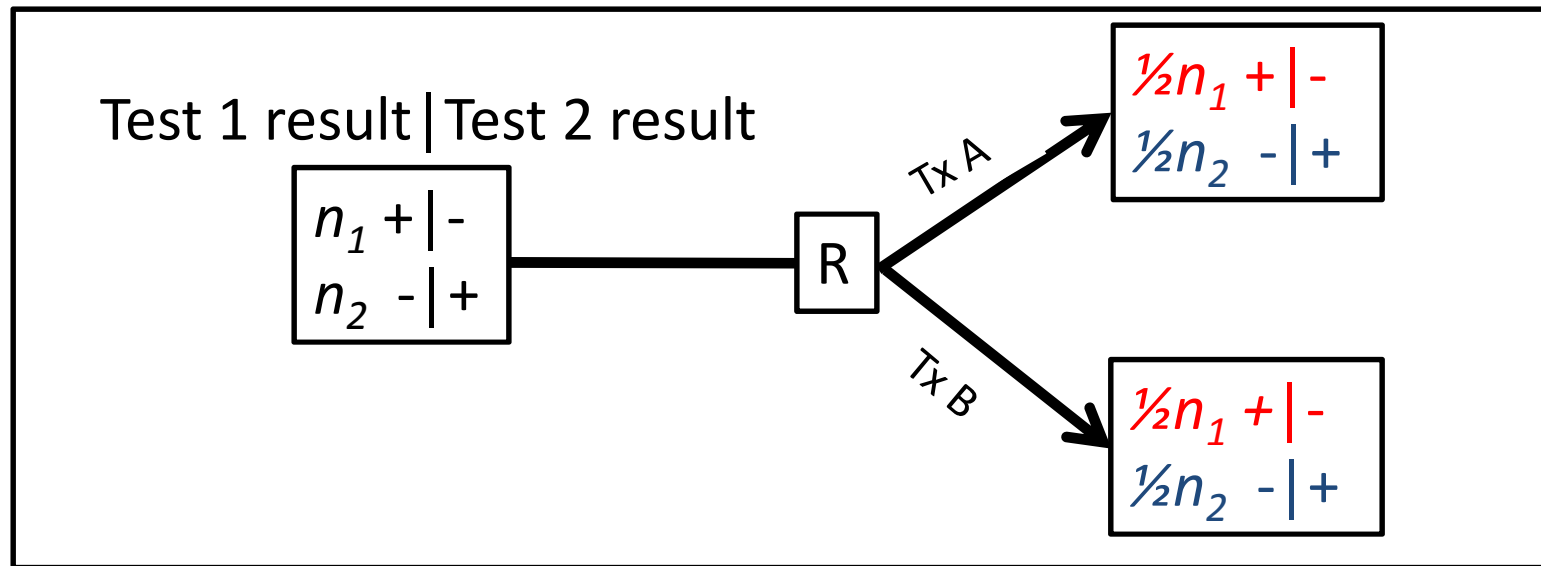
Question: For discordant patients, which treatment is better?



## 2. Statistical Analysis: Treatment Effect of Test results

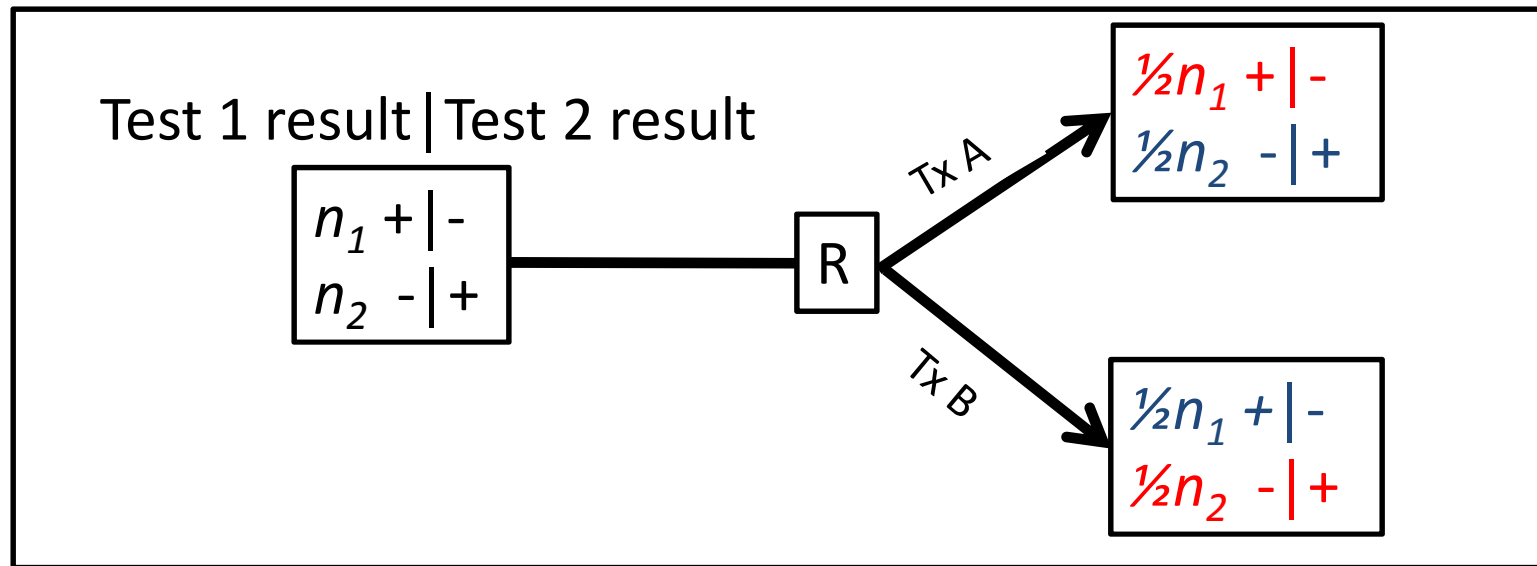
$n_1 + | -$  versus  $n_2 - | +$

When patients with one discordant result are randomly treated with A or B, does  $+ | -$  (+ Test 1) have better outcomes than  $- | +$  (+ Test 2)?



### 3. Statistical Analysis: Clinical pathway (strategy based on test method)

With appropriate treatment does Test 1 have better outcomes than Test 2?



# 3. Statistical Analysis: Clinical pathway (strategy based on test method)

## Another view

Strategy based on Medical Test 1

1	2	Tx	Favorable outcome	Poor outcome
+	-	A		
-	+	B		

Strategy based on Medical Test 2

1	2	Tx	Favorable outcome	Poor outcome
-	+	A		
+	-	B		

Absolute risk difference of clinical pathway Test 1 compared to clinical pathway Test 2

=

Difference in favorable outcome rate, after correcting for frequency of discordant

Note: To calculate the RR or total risk, need outcome rate for concordant group

(Ligmer & Bossuyt, Evidence Base of Clinical Diagnosis, 2009)

# 3. Clinical Pathway - Example

5% discordant rate

$$n_1 (+|-) = 22, \frac{1}{2}n_1 (+|-) = 11$$

$$n_2 (-|+) = 200, \frac{1}{2}n_2 (-|+) = 100$$

Total patient for each clinical pathway = 111

Strategy based on Medical Test 1

1	2	Tx	Favorable outcome	Poor outcome
+	-	A	10	1
-	+	B	50	50

60/111=0.54 favorable outcome

Strategy based on Medical Test 2

1	2	Tx	Favorable outcome	Poor outcome
-	+	A	90	10
+	-	B	10	1

100/111=0.90 favorable outcome

36% absolute difference risk difference in favor of Test 2 for discordant  $\times$  5% discordant rate =  
1.8% absolute risk different in favor of Test 2

# Paired Diagnostic tests with 3 ( $k$ ) treatment options

		<i>Medical Test 2</i>		
		<b>Tx A</b>	<b>Tx B</b>	<b>Tx C</b>
<i>Medical Test 1</i>	<b>Tx A</b>	Same	A/B	A/C
	<b>Tx B</b>	B/A	Same	B/C
	<b>Tx C</b>	C/A	C/B	Same

Strategy based on Medical Test 1

Strategy based on Medical Test 2

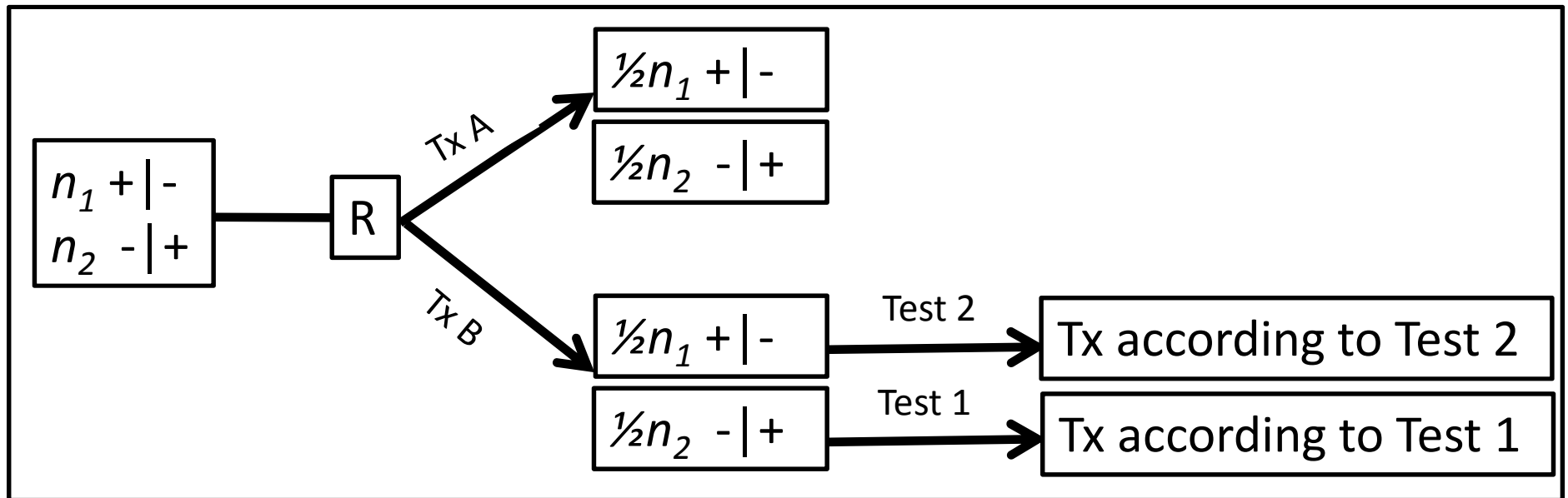
1	2	Tx	Favorable outcome	Poor outcome
A	B	A		
A	C	A		
B	A	B		
B	C	B		
C	A	C		
C	B	C		

1	2	Tx	Favorable outcome	Poor outcome
B	A	A		
C	A	A		
A	B	B		
C	B	B		
A	C	C		
B	C	C		

Same Analysis 2 test, 2 treatment

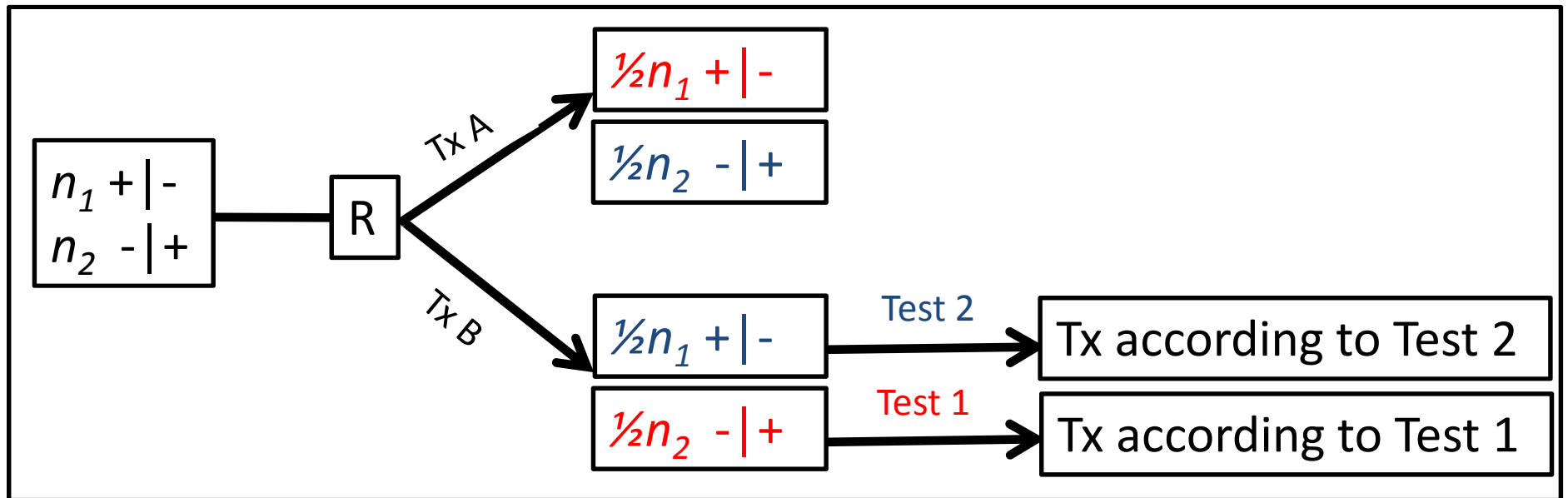
# Serial Medical Testing

- Serial Screening (mammography every 2 year)
- Therametrics – quantification of therapeutic parameters in management of disease (viral load HIV<sub>(Reed 1996)</sub>, serum c-erB-2 breast cancer<sub>(Fehm 1997)</sub>)



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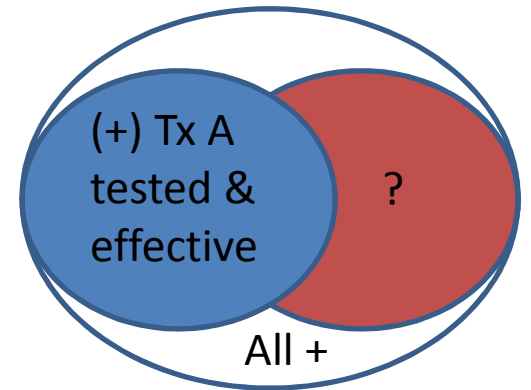


Same Analysis as 2 test, k treatment



# Future direction

- This design should be performed even if a new test has the same sensitivity, but is cheaper/easier to conduct, etc.
- Continuous outcome with and without censoring
- Non-inferiority



# Thank You

## Contributors and Advisers

Richard Chappell

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## Support

UW MSTP

UW ICTR (TL1)