Supplementary technical note -

Statistical methods to assess the association between surrogate and final endpoints

**Methods to examine observation-level association**

Seven papers reported the relationship between median PFS or TTP and median OS using aggregate data.1-7 Three treated both surrogate endpoints as different,2,4,6 with one performing separate analyses for PFS, TTP and a composite measure including both PFS and TTP.4 Two studies also examined the relationship between OS and post-progression survival (PPS), which was defined as the difference between median OS and median PFS or TTP.3,7 In order to assess the correlation between the surrogate and final endpoints, five papers reported Spearman’s ρ correlation coefficients,1,2,4,5,7 one reported the Pearson product-moment correlation coefficient,4 and three the coefficient of determination (R2) or regression parameters derived from a linear regression analysis.1,3,6 Statistical analyses were often weighted by trial size. Three papers included a variety of first-line treatments,1-3 and one included only second- or third-line treatments.7 In studies that included patients at different treatment lines, such line was a stratification factor in multivariate analyses (see Supplementary Table 3).

Seven IPD meta-analyses estimated ‘individual-level’ surrogacy between PFS or TTP and OS,8-14 with the last two distinguishing between TTP and PFS or only considering TTP (on the log scale). Correlation between the surrogate and final endpoints at the individual-level was expressed through Spearman’s ρ8,9 or Pearson’s13 correlation coefficients, whereas two studies considered the patient-level agreement between PFS and OS at different time points,10,11 with the latter study reporting a Kappa statistic to summarise the amount of agreement beyond that expected by chance alone. Individual-level correlation coefficients were derived from random-effects linear models of the association between normally distributed endpoints.10,15 For failure-time endpoints,8,12 Kendall’s τ was used as a measure of the association between the surrogate and final endpoints, modelled through Hougaard’s or Clayton’ bivariate copula models. Landmark analysis16 was used in six papers to assess the prognostic impact of being alive and progression-free at various timepoints on future survival.11,17-21 In the landmark analysis, multivariate Cox proportional hazards models were constructed for OS and these were stratified by progression-free status at consecutive times. HRs were reported for survival in patients who were alive and progression-free at these timepoints compared with those who were not. Three of the models were stratified by trial protocol,17,18,21 while one reported separate analyses for each trial and a combined analysis adjusted for study protocol.20 Two papers assessed the Kendall’s τ rank correlation coefficient for bivariate censored data,18,19 while Heng and colleagues19 also assessed the correlation between PFS and OS using the Fleischer model.22 Mandrekar and colleagues21 and Foster and colleagues17 evaluated model discrimination using the concordance index (c-index), which computes the probability that, for a pair of randomly chosen comparable patients, the patient with the lower risk prediction (e.g., progression-free at 3 months) will experience an event (e.g., death) before the higher risk patient (e.g., progressed before 3 months). A completely random prediction would have a c-index of 0·5, and perfect correlation will produce a c-index of 1·0.21 Buyse et al.8 and Halabi et al.18 performed a validation procedure of their estimated models by dividing their samples into a training and a testing set.

**Methods to examine treatment-level association**

Fourteen studies examined the relationship between the treatment effect on PFS or TTP and the treatment effect on OS based on aggregate data.2,4,5,23-33 Treatment effect was defined in several ways: absolute difference in medians of time-to-event endpoints,2,24,30,33 proportional increase in medians of such endpoints,25,26,31 or HRs.4,5,23,27,28,30,32 One paper defined the treatment effect as the HR minus unity,29 and another examined the percent risk reduction based on the HR.2 Some authors transformed the HR onto a log scale for the linear regression,23,28,33 and most of them defined the HR as the ratio of the median time-to-event between trial arms,4,23,27-29 which implicitly assumes that the underlying distribution of event-free survival is exponential, although no justification was given for this assumption. The studies handled trials with more than two arms in a variety of ways. Most included multiple comparisons from the same trial as multiple points in the analysis without accounting for the correlations between them or the double-counting in terms of the sample size.5,23,25,27,30,33 Linear regression analyses were the most common methods used to assess the relationship between treatment effect on PFS or TTP and treatment effect on OS based on summary data from multiple RCTs.2,4,23,24,27-30,32,33 All but two reported that the regression analyses were weighted according to trial size.2,30 Two studies did not force the intercept of the regression to zero,2,29 although both considered and discounted a non-zero intercept in exploratory analyses. One study explored the possibility of a nonlinear regression by adding quadratic terms.29 One study33 assessed the possibility of publication bias using funnel plot and Egger’s test.34 One study examined residual versus predicted plots and undertook diagnostic tests for normality and heteroscedasticity (non-constant error variance) to assess consistency with the assumptions of linear regression,24 and another study evaluated the normality assumption and presence of outliers or influential points using diagnostic tests and plots.4 Several authors used multivariate analysis to explore whether any other factors were significant predictors of treatment effect on OS (see Supplementary Table 3).4,24,27,33 A ‘leave-one-out’ cross-validation to predict the OS HR from the PFS HR for each trial using a regression fitted to all the remaining trials was performed in two studies.4,28 Other metrics used to ev1aluate trial-level surrogacy were the surrogate threshold effect (STE),24 the Spearman’s ρ,2,4,5,25,26,31 or Pearson’s correlation coefficients,4,29,32,33 Kappa test for agreement,28,29 or hypothesis sign test.25,26,31 One paper built a receiver operating characteristics curve, a graphical display of the trade-off between sensitivity and specificity at various magnitudes of treatment effect for PFS, to assess whether the candidate surrogate endpoint is predictive of a clinically meaningful treatment effect in OS.4

Seven IPD meta-analyses reported estimates of the association between treatment effects on the surrogate and final endpoints.8-10,12,14,17,35 Within the meta-analytic framework, trial-level surrogacy must be based on results from several randomized trials.36 However, when an insufficient number of trials are available to conduct a meta-analysis, it is possible to break the results of large trials down into smaller units of analysis,34 such as study centres. This expedient was used in four of the included studies.10,12,14,17 Most of these studies expressed treatment effect as HRs for PFS, TTP and OS on the log scale,8-10,17 while one study considered the absolute difference on TTP and OS on the log scale.14 For the evaluation of the surrogate endpoints on the basis of IPD, the authors used joint models of the surrogate and the final endpoint as continuous bivariate normally distributed,14 or time-to-event variables. Burzykowski and colleagues9 used copula models, either Clayton’s or Hougaard’s types, to estimate trial- or centre-specific treatment effects on PFS or TTP and OS. Variations proposed to overcome statistical challenges for the computation and definition of the correlation coefficients in different situations have been discussed elsewhere.36,37 In one paper, the regression was validated by using it to predict OS treatment effects from PFS treatment effects in three validation trials.8 Burzykowski and Buyse35 introduced the concept of STE for the first time and reported the minimum HR required for PFS in order to observe a significant treatment benefit on OS in the context of advanced ovarian and colorectal cancers.

Supplementary Table 1 Biomarker-Surrogacy Evaluation Schema (BSES3)§

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| --- |
| **Biomarker-surrogate domains** |
| **Study design** | 0 Biological plausibility and lower quality clinical studies1 Rank 0 and at least 2 good quality prospective observational cohort studies measuring the surrogate and the target outcomes2 Rank 1 and at least 2 high quality adequately powered RCTs measuring the surrogate and the target outcomes3 Rank 1 and at least 5 high quality adequately powered RCTs measuring the surrogate and the target outcomes |
| **Target outcome** | 0 Target is reversible disease-centred biomarker of harm1 Target is irreversible disease-centred biomarker of harm2 Target is patient-centred endpoint of reversible organ morbidity or clinical burden of disease or clinical harm3 Target is patient-centred endpoint of irreversible organ morbidity or clinical burden of disease or severe irreversible clinical harm or death |
| **Statistical evaluation of the biomarker-surrogate vs. target outcome** | 0 Poor: Does not meet the criteria for Rank 11 Fair: RCT R2trial ≥ 0.2 AND STEP\* ≥ 0.1 OR cohort data R2ind ≥ 0.42 Good: RCT R2trial ≥ 0.4 AND STEP ≥ 0.2 AND R2ind ≥ 0.43 Excellent: RCT R2trial ≥ 0.6 AND STEP ≥ 0.3 AND R2ind ≥ 0.6\*\* |
| **Generalisability: clinical evidence across different risk populations and pharmacologic evidence across different drug-class mechanisms** | 0 No clinical or pharmacologic evidence1 Clinical OR pharmacologic evidence2 Clinical AND pharmacologic evidence3 Consistent Clinical RCT AND pharmacologic RCT evidence |
| **Level of evidence of surrogate endpoint multidimensional validity** |
| 12  | Level A |
| 11 – 9  | Level B+, B, B- |
| 8 – 6 | Level C+, C, C-, D+, D, D- |
| 5 – 3  | Level D+, D, D-, E+, E, E- |
| 2 – 0 | Level E+, E, E-, F+, F, F- |

§Adapted from Lassere MN, Johnson KR, Schiff M, Rees D. Is blood pressure reduction a valid surrogate endpoint for stroke prevention? An analysis incorporating a systematic review of randomised controlled trials, a by-trial weighted errors-in-variables regression, the surrogate threshold effect (STE) and the Biomarker-Surrogacy (BioSurrogate) Evaluation Schema (BSES). *BMC Medical Research Methodology* 2012 Mar 12; **12**:27. doi: 10.1186/1471-2288-12-27.

\* STEP is defined as the proportion of the total range of the surrogate that is equal or larger than the STE

\*\*Without data subdivision. Some analyses with few trials subdivide into centres to increase the number of data points

Supplementary Table 2 Detailed characteristics of included meta-analyses, summary of statistical methods used and results

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **First author and year** | **Tumour type** | **Study identification** | **Inclusion criteria**  | **N. of studies (patients)**  | **Surrogate and final outcome relationships analysed**  | **Statistical methods used to assess surrogate and final outcome association** | **Results** |
| **Summary data from trials** |
| Louvet et al. 20011  | mCRC | Not stated | Phase III studies of first line treatment reported between 1990 and 2000, >100 patients per study arm | 2913,498 | Median PFS and median OS for individual trial arms | Spearman ρ correlation coefficient Linear regression | ρ =0.481, p <0.0001OS (months) = 0.68 x PFS (months) + 8.74 |
| Hackshaw et al. 200523 | mBC | Systematic search (Medline 1966-2005) | RCT comparing FAC or FEC with one or more first-line combination therapies | 42 (9,163) | HR for TTP and OS (HR defined as ratio of median survival) | Linear regression on log-log scale weighted by sample size | Log10 HRTTP = 0.0135+0.5082 x log10 HROS(p <0.001, R2 = 56%, s.e. = 0.0928) |
| Johnson et al. 200624 | mCRC, mNSCLC | Systematic search | RCTs of first-line treatment | CRC: 146 (35,557)NSCLC: 191(44,125) | Difference in median TTP and median OS | Linear regression weighted by trial size (multivariate analysis used to explore other potential predictive factors)STE for various trial sizes | mCRC:R2 = 0.33; p <0.0001OS = –0.002 + 0.0961 x TTPmNSCLC:R2 = 0.19; p =0.0003OS = 0.189 + 0.616 x TTPmCRC: 3.3 months mNSCLC: 3.2 months for trials of 250 patients |
| Tang et al. 20072 | mCRC  | Systematic search | Randomised trials of first-line treatment published between 1990 and 2005, >100 patients per arm, mature data on OS and either TTP or PFS | 39(18,668) | Median PFS/TTP and OSDifferences (Δ) in median OS, PFS and TTPHRs PFS and OS  | Nonparametric Spearman rank correlationLinear regression (through origin) analysis | Median PFS and OS: ρ = 0.79 (95% CI, 0.65 to 0.87), p <0.000001Median TTP and OS:ρ = 0.24 (95% CI,-0.13 to 0.55), p =0.21ΔPFS and ΔOS : ρ = 0.74 (95% CI, 0.47 to 0.88), p = 0.00004Slope = 1.02 (s.e. = 0.16), R2=0.65ΔTTP and ΔOS :ρ = 0.52 (95% CI, 0.004 to 0.81), p = 0.05HRPFS and HROS: Slope = 0.54 (s.e. = 0.10) |
| Bowater et al. 200825 | mBC, mCRC, HRPmNSCLC | Systematic search for reviews of RCT  | RCTs published in English between 1990 and 2007 comparing two different chemotherapy treatments  | BC: 33 (NS)CRC: 38(NS)HRP: 23(NS)NSCLC: 13(NS) | Gain (%) in median TTP and in post-progression survival (PPS) (PPS= median OS – median TTP) | Spearman’s correlationHypothesis (sign) test for proportion of trials witha) PPS%gain < TTP%gain,b) PPS%gain <0.5TTP%gain | ρ was non-significant at 10% level in all fourdisease areasa) p <0.001 for all four disease areasb) p <0.005 for colorectal and p<0.001 for three other disease areas |
| Hotta et al. 200927 | Advanced or mNSCLC | Systematic search | Phase III trials of first-line therapies published between 1994 and 2006 | 54(23,457) | Ratio of medians TTP and MST | Linear regression on ratios of medians TTP and MSTMultivariate linear regression on on ratios of medians TTP and MST (weighted by trial size) incorporating 6 other factors | R2 = 0.33, p <0.01Multivariate analysis (R2 = 0.41) gave regressioncoefficient of 0.32 (p <0.01) for TTP and no otherfactor was significant |
| Miksad et al. 200828 | Advanced breast (some locally advanced included) | Systematic search | RCTs published in English of anthracyclines and taxanes | 31(4,323) | HR for PFS and OS estimated by calculating the median OS andPFS ratios for each pair of trials arms | Kappa tests for agreement in direction ofeffects (HR)Fixed effects linear regression for LogHR(weighted by sample size) | Anthracyclines: Kappa = 0.71 (95% CI, 0.36 to 1.00, p =0.0029)Taxanes:Kappa = 0.75 (95% CI, 0.42 to 1.00, p =0.0028)Anthracyclines: R2 = 0.49, p =0.0019log10HROS = -0.011 + 0.259log10HRPFSTaxanes: R2 = 0.35, p =0.012log10HROS = 0.014 + 0.499log10HRPFS |
| Sherrill et al. 200829 | mBC | Systematic search | RCTs published after 1994 | 67(17,081) | Treatment effects for TTP/PFS and OS (HR-1)Significance of treatment effect in TTP/PFS and OS | Linear regression (through origin) on treatment effect weighted by sample sizeUnweighted Pearson correlation between HRKappa test for agreement onsignificant treatment effect | Slope = 0.32 (95% CI, 0.20 to 0.43), R2 = 0.30R = 0.46Kappa = 0.47, p <0.05 |
| Wilkerson and Fojo 200930 | mBCmCRCmOC | “non -exhaustive” search | Randomised trials showing a statistically significant difference in either PFS or OS or their HRs | 66(NS) | Differences in median PFS and OSHR for PFS and OS | Linear regression on differences in mediansLinear regression HRPFS vs HROS | Slope = 1.214 (95%CI 0.89 to 1.54), R2 = 0.49, p <0.0001mCRC: R2 = 0.61 p < 0.0001mOC: R2 = 0.60 p = 0.0007mBC: R2 = 0.30 p = 0.018R2 = 0.62, p <0.0001mCRC: R2 = 0.52 p = 0.0021mOC: R2 = 0.73 p = 0.02mBC: R2 = 0.70 and p = 0.0015 |
| Bowater et al. 201126 | mBC mCRC (also locally advanced disease) | Systematic search | RCTs published in English between 1998 and 2008 comparing two different chemotherapy treatments | mBC: 95(NS) mCRC: 74(NS)  | Gain (%) in median TTP and PPS (PPS = median OS – median TTP) | Spearman’s rank correlation for gainHypothesis (sign) test for proportion of trials witha) PPS%gain < TTP%gainb) PPS%gain <0.5TTP%gain | mBC: ρ = 0.37 mCRC: ρ = 0.11 a) p <0.01 for both tumour typesb) p<0.01 for both tumour types |
| Hotta et al. 20113 | Advanced or metastatic NSCLC | Systematic search | Phase III trials of first-line therapy | 70(38,721) | Median OS, PFS and PPS (PPS= median OS – median PFS) | Linear regression analysis weighted by trial size | Median OS and PFS:R2 = 0.2563 Median OS and PPS:R2 = 0.8917  |
| Chirila et al. 20124 | mCRC  | Systematic search | Randomised phase II and III trials with at least 20 participants | 62(23,527) | Median PFS/TTP and OS HR for PFS/TTP and OS (HR defined as ratio of medians) | Pearson product-moment correlationSpearman’s rank correlationWeighted least squares regression weighted by trial sizeDiagnostic evaluation of regression equations (ROC curves for outcome of HRos ≤0.8) | PFS: 0.89 (95%CI 0.83 – 0.93)TTP: 0.75 (95%CI 0.59 – 0.84)PFS/TTP: 0.87 (95%CI, 0.82 to 0.91)PFS: 0.78 (95%CI, 0.66 to 0.85)TTP: 0.59 (95%CI 0.37 – 0.74)PFS/TTP: 0.76 (95%CI, 0.67 to 0.82)Ratio of Medians PFS/TTP and OS: Slope = 0.41 (95%CI, 0.30 to 0.52), intercept = 0.60 (95%CI, 0.49 to 0.71), R2 = 0.48Ratio of Medians PFS and OS: Slope = 0.49 (95%CI, 0.35 to 0.64),intercept = 0.52 (95%CI, 0.39 to 0.66), R2 = 0.59Ratio of Medians TTP and OS: Slope = 0.31 (95%CI, 0.12 to 0.49),intercept = 0.71 (95%CI, 0.53 to 0.90), R2 = 0.32AUC = 0.795 (p <0.01)HRPFS ≤0.78 has sensitivity =0.89 and specificity=0.69 |
| Shitara et al. 20125 | Advanced gastric  | Systematic search | Randomised phase II and III trials of systemic chemotherapy | 36(10,484) | Median PFS/TTP and OS HR of PFS/TTP and OS | Spearman’s rank correlation (also by subgroups) | Median PFS/TTP and OS:ρ = 0.70 (95%CI, 0.59 to 0.82), p <0.001HR PFS/TTP and OS:ρ = 0.80 (95%CI, 0.68 to 0.92), p <0.0001 |
| Sundar et al. 201231 | mOC | Systematic search | Any randomised controlled trials of chemotherapy in treating metastatic ovarian cancer | 37(15,850) | Gain (%) in median PFS/TTP and PPS  | Spearman’s rank correlation for gainHypothesis (sign) test for proportion of trials witha) PPS%gain = 0 b) PPS%gain > PFS/TTP %gain | Gain in median PFS/TTP and PPS in primary treatment:ρ = 0.06, p = 0.69Gain in median PFS/TTP and PPS at recurrence: ρ = −0.234 (95%CI, -0.73 to 0.43), p = 0.49a) p =0.85 in primary treatment, p = 0.99 at recurrenceb) p = 0.23 at recurrence |
| Amir et al. 201232 | mPancreatic mNSCLC, mCRC, mRCCl,mHNCmBCmOC | Purposive sampling of RCTs | RCTs supporting registration of new anti-cancer drugs approved by the US FDA in the last 10 years | 26(NS) | HR of PFS/TTP and OS | Linear regression weighted by the trial sample size (Pearson coefficient) | HR for OS and PFS:R = 0.64 for the group with PPS<12 monthsR = 0.38 for the group with PPS≥12 months |
| Li et al. 20126 | Advanced NSCLC | Systematic search | Phase II and Phase III (randomised and non randomised) Clinical trials published before August 2011 assessing gefitinib or erlotinib monotherapy | 60(9,903) | Median PFS or TTP and Median Survival time | Linear regression weighted by the trial sample size, also adjusted by covariatesROC analysis (AUC) to examine accuracy in prediction of MST | PFS and MST:R2 = 0.70, p < 0.0001R2 = 0.74, p < 0.001 (adjusted)PFS and MST (adjusted):R2 = 0.89, p < 0.001Slope = 1.74, s.e. = 0.25TTP and MST:R2 = 0.04, p = 0.512AUCPFS = 81.5, p = 0.076AUCPFS = 94, p = 0.842 (adjusted) |
| Hayashi et al. 20127 | Advanced or mNSCLC | Systematic search | RCTs phase III published in English between 2000 and April 2011 that compared two or more systemic chemotherapies in patients with disease recurrence after chemotherapy | 18(11,310) | Median OS, median PFS/TTP, median PPSIncremental gains in median OS and median PFS/TTP | Spearman’s rank correlation (weighted by the number of patients in each arm) | Median PFS/TTP and median OS:ρ = 0.51, p = 0.001Absolute gains in median OS and median PFS/TTP: ρ = 0.29, p < 0.0001 |
| Delea et al. 201233 | mRCC | Systematic search | Clinical trials published in English between 1997 and 2010 | 31(10,943) | Absolute differences between median PFS/TTP, PFS or TTP and median OS Negative of the LogHR for PFS/TTP, PFS or TTP and OS | Pearson correlation coefficients (Multivariate) Ordinary least squares regression (weighted by samples size or inverse of the variance) | Absolute difference in median PFS/TTP and OS: ρ = 0.54, p = 0.0002 Intercept = 0.13 (95% CI, -1.44 to 0.77)Slope = 1.17 (95%CI, 0.59 to 1.76) R2 = 0.28 PFS and OS: ρ = 0.55, Slope = 1.21 (95%CI, 0.56 to 1.86) R2 = 0.28TTP and OS: ρ = -0.10, Slope = -0.21 (95%CI, -2.98 to 2.56) R2 = -0.24–logHRPFS/TTP and -logHROS: ρ = 0.80, p < 0.0001Intercept = -0.04 (95% CI, -0.12 to 0.04) Slope = 0.64 (95%CI, 0.08 to 0.47) R2 = 0.63-logHRPFS and -logHROS: ρ = 0.81, Slope = 0.68 (95%CI, 0.49 to 0.86) R2 = 0.65-logHRTTP and -logHROS: ρ = 0.64, Slope = 0.17 (95%CI, -0.20 to 0.53) R2 = 0.21 |
| **Individual patient level data** |
| Buyse et al. 20078 | Advanced CRC  | Not stated but all had individual patient data  | RCTs with a FU+leucovorin treatment arm | Historic: 10(3,089)Validation: 3(1,263) | Individual level: 6 months PFS and 12 months OSPFS and OS over entire time rangeTrial level: HR forPFS and OS | Rank correlation coefficient for PFS at 6 months and OS at 12 monthsRank correlation coefficient for PFS and OS for entire time rangeLinear regression for treatment effects (logHR) on PFS and OSSTE | ρ = 0.32 (95% CI,-0.14 to 0.67)ρ = 0.82 (95% CI, 0.82 to 0.83)R was equal to 0.99 (95% CI, 0.94 to 1.04) (R2 = 0.98)log HROS = 0.003 + 0.81xlog HRPFSSTE HRPFS = 0.86 |
| Burzykowski et al. 20089 | mBC | Not stated but all had individual patient data | Randomised trials comparing anthracycline with taxane (both single agent and combination therapy) | 11 (3,953) | Individual level: PFS, TTP and OSTrial level: HR for PFS, TTP and OS | Spearman's rank correlation coefficient for correlation between endpointsSpearman's rank correlation coefficient for treatment effects (HR) on endpointsHougaard copula model of the relationship between treatment effects (logHR) | Individual PFS and OS: ρ = 0.688; (95% CI, 0.686 to 0.690)Individual TTP and OS: ρ = 0.682; (95% CI, 0.680 to 0.684)LogHR for PFS and OS: ρ = 0.48 (95% CI, -0.34 to 1.30)LogHR for TTP and OS: ρ = 0.49 (95% CI,-0.32 to 1.30)Regression parameters not reported |
| Foster et al. 201117 | SCLC | Consecutive trials from the NCCTG | First-line trials (phase II and III), randomised and non randomised, that included either a platinum or taxol based regimen | 9(870) | Individual level: PFS status at 2,4,6 months and OSTrial level: LogHR by trial centre (32 units) for PFS and OS | Individual: Multivariate landmark analysis for OS by PFS at 2,4,6 months and c-indexTrial level:Weighted least square regressionSpearman correlation coefficientBivariate survival model (Copula) | Individual:2month: HR = 0.40 (95%CI, 0.30 to 0.52), c-index = 0.604month: HR = 0.42 (95%CI, 0.35 to 0.51), c-index = 0.636month: HR = 0.41 (95%CI, 0.35 to 0.49), c-index = 0.65Trial level:WLS R2 = 0.79Spearman ρ = 0.75Copula R2 = 0.80 |
| Halabi et al. 200918 | Progressive castrate-resistant prostateCancer | Not stated | Phase II and III multicentre trials conducted by CALGB | 9(1,296) | Individual patient data on PFS and OS | Landmark analysis for OS by PFS at 3 months, 6 monthsKendall τ for association between PFS and OS | 3month PFS: HR = 2.0 (95% CI, 1.7 to 2.4; p <0.001)6month PFS:1.9 (95% CI, 1.6 to 2.4; p <0.001)τ = 0.30 (bootstrap s.e. = 0.0172, 95% CI, 0.26 to 0.32, p <0.00001) |
| Heng et al. 201119 | mRCC | Not relevant | Consecutive population based samples treated on clinical trial or offprotocol at 12 cancer centres | NS(1,158) | Individual patient data on PFS and OS | Landmark analysis of OS by PFS at 3 months, 6 monthsKendall τ for PFS and OSFleischer’s model correlation | 3month: HR = 3.05 (95% CI, 2.42 to 3.84)6month: HR = 2.96 (95% CI, 2.39 to 3.67)0.42 (bootstrap s.e., 0.016, 95% CI, 0.39 to 0.45, p <.0001)0.66 (bootstrap s.e., 0.025, 95% CI, 0.61 to 0.71) |
| Polley et al. 201020 | Brain (GBM) | Not relevant | Phase II trials conducted at a single institution | 3(193) | Individual patient data on PFS and OS | Landmark analysis for OS by PFS at 10 weeks, 18 weeks, 26 weeks | 10weeks: HR = 3.55 (95%CI, 2.28 to 5.52)18weeks: HR = 2.06 (95%CI, 1.43 to 2.99)26weeks: HR = 1.99 (95%CI, 1.38 to 2.85)(combined across all trials) |
| Mandrekar et al. 201021 | Advanced NSCLC | Not relevant | Consecutive NCCTG phase II trials | 4(284) | Individual patient data on PFS and OS | Landmark analysis for OS by PFS at 8 weeks, 12 weeks, 16 weeks, 20 weeks, 24 weeks | 8 weeks: HR = 0.45 (95%CI, 0.33 to 0.62), p <0.0001,c-index = 0.6312 weeks: HR = 0.39 (95%CI, 0.28 to 0.52), p <0.0001, c-index = 0.6716 weeks: HR = 0.49 (95%CI, 0.36 to 0.65), p <0.0001,c-index = 0.6620 weeks: HR = 0.41 (95%CI, 0.30 to 0.55), p <0.0001,c-index = 0.6824 weeks: HR = 0.41 (95%CI, 0.30 to 0.57), p <0.0001, c-index = 0.68 |
| Green et al. 200810 | Advanced CRC | Not stated but all had individual patient data | NS  | 10(NS) | Rate of PFS1-year and OS2-year, OS5-yearHR of PFS1-year and OS2-year | Per-patient agreement between endpoints (%)Study-wise agreementLinear regression weighted by the trial sample sizeSpearman’s rank correlationIndividual-level correlation estimated using a bivariate survival model Trial-level correlation estimated using a bivariate survival modelProportion of treatment effect (PTE) on OS explained by PFS  | PFS1-year and OS2-year: Agreement = 89%8/10 trials yield same conclusionsR2 = 0.002OS2-year rate= 0.21 + 0.03 x PFS1-year rateSlope s.e. = 0.19, p >0.20; Intercept s.e. = 0.03, p <0.001ρ = 0.13HRPFS1-year and HROS2-year:R2 = 0.84HROS2-year = 0.44 + 0.57 x HRPFS1-year Slope s.e. = 0.09, p = 0.0002; Intercept s.e. = 0.122, p =0.007ρ = 0.92HRPFS1-year and HROS2-year:R2indiv = 0.61 (95% CI, 0.59 to 0.64)R2trial = 0.58 (95% CI, 0.18 to 0.98)PTE > 100% |
| Burzykowski and Buyse 200635 | Advanced CRCAdvanced ovarian | Not stated but all had individual patient data (same as Burzykowski et al. 2001)  | NS | CRC: 2(642)OC: 4(1,194) | CRC: Center-based HR of PFS and OS (log scale)OC: Center-based for the two larger trials, and trial-based for the two smaller trials HR of PFS and OS (log scale) | Hougaard copula model of the relationship between treatment effects (log scale) Surrogate threshold effect (using estimates for model parameters and prediction variance to correct for estimation) | Advanced colorectal:LogHRPFS = 0.021, Var = 1.149LogHROS = 0.003, Var = 0.737R2Trial = 0.53 (95% CI, 0.34 to 0.72)R2Trial = 0.64 (adjusted for the estimation error in treatment effects)Advanced ovarian:LogHRPFS = -0.20, Var = 1.02LogHROS = -0.18, Var = 0.93R2Trial = 0.88 (95% CI, 0.81 to 0.95)R2Trial = 0.83 (adjusted for the estimation error in treatment effects)Advanced colorectal:STE on logHRPFS = -2.11 STE on logHRPFS = -3.11 (adjusted)STE on HRPFS = 0.12STE on HRPFS = 0.04 (adjusted)Advanced ovarian:STE on logHRPFS = -0.75 STE on logHRPFS = -0.61 (adjusted)STE on HRPFS = 0.47STE on HRPFS = 0.54 (adjusted) |
| Ballman et al. 200711 | Brain (GBM) | All trials of newly diagnosed and recurrent GBM conducted by the NCCTG | Trials conducted by the NCCTG on newly diagnosed and recurrent GBM patients  | 27(1,693)Newly diagnosed:11 (1,348)Recurrent:16 (345) | PFS6months and OS12monthsPFS6months and OS | Patient-level agreementKappa statisticsLinear regression weighted by the trialsample sizeLandmark analysis OS by PFS6months | Newly diagnosed GBM: 75%K = 0.48 (95% CI, 0.44 to 0.53) Recurrent GBM: 88%K = 0.52 (95% CI, 0.39 to 0.65)Newly diagnosed GBM: OS12months = 0.24 + 0.40 x PFS6monthsp slope = 0.09R2 = 0.28Recurrent GBM:OS12months = 0.08 + 0.61 x PFS6monthsp slope = 0.01R2 = 0.41Newly diagnosed: HR = 2.1 (95% CI, 1.8 to 2.4)Recurrent: HR = 2.4 (95% CI, 1.6 to 3.8) |
| Rose et al. 201013 | mOC | Exploratory data analysis | A series of consecutive GOG second-line phase II trials in the setting of platinum-resistant cancer | 11 (407) | Aggregate PFS6months rates and median OS | Pearson correlation coefficient Kendall τ-b correlation coefficient | PFS6months and median OS:Pearson r = 0.661, p = 0.027Kendall τ-b r = 0.514, p = 0.029 |
| Buyse et al. 200014 | Advanced ovarian | Trials in the Ovarian Cancer Meta-analysis Project. All had individual patient data. | Not stated | 4(1,194) | Individual level:LogTTP and LogOSTrial level:TE on LogTTP and LogOS (absolute difference) | Prentice criteria tests of significance of association between endpointsFreedman’s proportion explainedRelative effectAdjusted associationRandom effects meta-analytic model of jointly normally distributed endpoints | LogTTP and LogOS:α, p = 0.003; β, p = 0.054; γ, p < 0.0001PE = 1.46 (95% CI, 0.80 to 2.13)RE = 0.60 (95% CI, 0.32 to 0.87)ρZ = 0.942 (95% CI, 0.94 to 0.95)R2trial = 0.951, s.e. = 0.098R2indiv = 0.888, s.e. = 0.006  |
| Burzykowski et al. 200112 | Advanced CRCAdvanced ovarian | OC: Trials in the Ovarian Cancer Meta-analysis Project. All had individual patient data | Not stated | CRC: 2(642)OC: 4(1,153) | Individual level:PFS and OSTrial level:CRC: Center-based HR of PFS and OS OC: Center-based for the two larger trials, and trial-based for the two smaller trials HR of PFS and OS  | Clayton’s copula model for the association between two failure time endpoints with common base-line hazardHougaard’s copula model for the association between two failure time endpoints with common base-line hazard | Advanced ovarian:R2Trial = 0.95 (95% CI, 0.76 to 1.14) (adjusted for the estimation error in treatment effects)τ = 0.857 (95%CI, 0.845 to 0.870)Advanced colorectal:R2Trial = 0.24 (95% CI, -0.40 to 0.89) (adjusted for the estimation error in treatment effects)τ = 0.502 (95%CI, 0.457 to 0.548)Advanced ovarian:R2Trial = 0.95 (95% CI, 0.82 to 1.07) (adjusted for the estimation error in treatment effects)τ = 0.839 (95%CI, 0.828 to 0.850) Advanced colorectal:R2Trial = 0.33 (95% CI, -0.69 to 1.36) (adjusted for the estimation error in treatment effects)τ = 0.583 (95%CI, 0.548 to 0.619) |

AUC = area under the curve; CALGB = Cancer and Leukemia Group B; mBC = metastatic breast cancer; mCRC = metastatic colorectal cancer; FAC = 5-fluorouracil, adriamycin and cyclophosphamide; FEC = 5-fluorouracil, epirubicin and cyclophosphamide; FU = fluorouracil; GBM = Glioblastoma multiforme; GOG = Gynecologic Oncology Group; HR = hazard ratio; HRP = hormone refractory prostate; MST = Median Survival time; NCCTG = North Central Cancer Treatment Group; NS = not stated; mNSCLC = metastatic Non-small cell lung cancer; mOC = metastatic ovarian cancer; OS = overall survival; PFS = progression free survival; PPS = post-progression survival; mRCC = metastatic renal cell carcinoma; RCT=randomised controlled trial; ROC = receiver operating characteristic; SCLC = small cell lung cancer; s.e. = standard error; STE = Surrogate Threshold Effect; TE = Treatment effect, TTP = time to progression; WLS = weighted list squares; Var = variance.

**Supplementary Table 3 Factors considered in multivariate analyses**

|  |  |
| --- | --- |
| **Reference** | **Factors analysed** |
| Johnson et al. 200624 | * Patients’ age (median)
* Performance status
* Stage of disease
 | * Year of trial
* Trial methodological quality
* Use of rescue (or salvage) treatment
 |
| Chirila et al. 20124 | * Line of therapy
* Performance status
* Clinical trial phase
* Crossover after progression
 | * Drug therapy
* Publication year
* Median OS for the control group
 |
| Hackshaw et al.23 | * Before/after 1990 when second line therapies not commonly used
 | * Death included in surrogate time-to-event outcome (i.e PFS not TTP)
 |
| Sherrill et al. 200829 | * Treatment class (hormonal, anthracyclines, first-line, non-first-line)
* Only HER2+ patients
* Study size (>100 per arm)
* TTP >6 mths in control arm
 | * Reported HRs
* ITT analyses
* Blinding
 |
| Miksad et al. 200828 | * Strict PFS definition
* Year last patient recruited
 | * First / subsequent line treatment
 |
| Hotta et al. 200927 | * Year of trial
* Old agents used
* Cisplatin used
* Carboplation used
* Full publication or abstract
* Description of sample size calculation
 | * Definition of primary endpoint
* Description of TTP definition
* Description of OS definition
* Description of definition for both TTP and OS
* Sample size
 |
| Shitara et al. 20125 | * PFS or TTP
* Trial area (Asian or non-Asian)
* Before 2006 or after 2006
* <200 or ≥200 patients
 | * Registration trial with investigational agents
* Number of chemotherapeutic agents in treatment arm
* Proportion of measurable disease
* Proportion of patients who received second-line chemotherapy
 |
| Li et al. 20126 | * Lines of therapy
* Patients origin
* Proportions of female patients
 | * Never-smokers
* Patients with adenocarcinoma histology
* Patients with performance status ≥ 2
 |
| Delea et al. 201233 | * Prior treatment
* Targeted therapy
* TTP or PFS
* Crossover allowed
 | * Year of publication
* <200 or ≥200 patients
* HR estimated from Kaplan-Meier curves
* Drug class
 |

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