Taking your agents to the clinic: phase I study design

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Dose finding

- Traditional goal: Find the highest dose with acceptable toxicity
- New goals:
  - find dose with sufficient effect on biomarker
  - find dose with acceptable toxicity and high efficacy
  - Find dose with acceptable toxicity in the presence of another agent that may also be escalated.

Acceptable toxicity

- What is acceptable rate of toxicity?
  - 20%?
  - 30%?
  - 50%?
- What is toxicity????
  - Standard in cancer: Grade 4 hematologic or grade 3/4 non-hematologic toxicity
  - Always?
  - Does it depend on reversibility of toxicity?
  - Does it depend on intensity of treatment?
    - Tamoxifen?
    - Chemotherapy?

Phase I study design

- "Standard" Phase I trials (in oncology) use what is often called the '3+3' design (aka 'modified Fibonacci'):

Treat 3 patients at dose K

1. If 0 patients experience dose-limiting toxicity (DLT), escalate to dose K+1
2. If 2 or more patients experience DLT, de-escalate to level K-1
3. If 1 patient experiences DLT, treat 3 more patients at dose level K
   A. If 1 of 6 experiences DLT, escalate to dose level K+1
   B. If 2 or more of 6 experiences DLT, de-escalate to level K-1

- Maximum tolerated dose (MTD) is considered highest dose at which 1 or 0 out of six patients experiences DLT.
- Doses need to be pre-specified
- Confidence in MTD is usually poor.

Should we use the “3+3”?

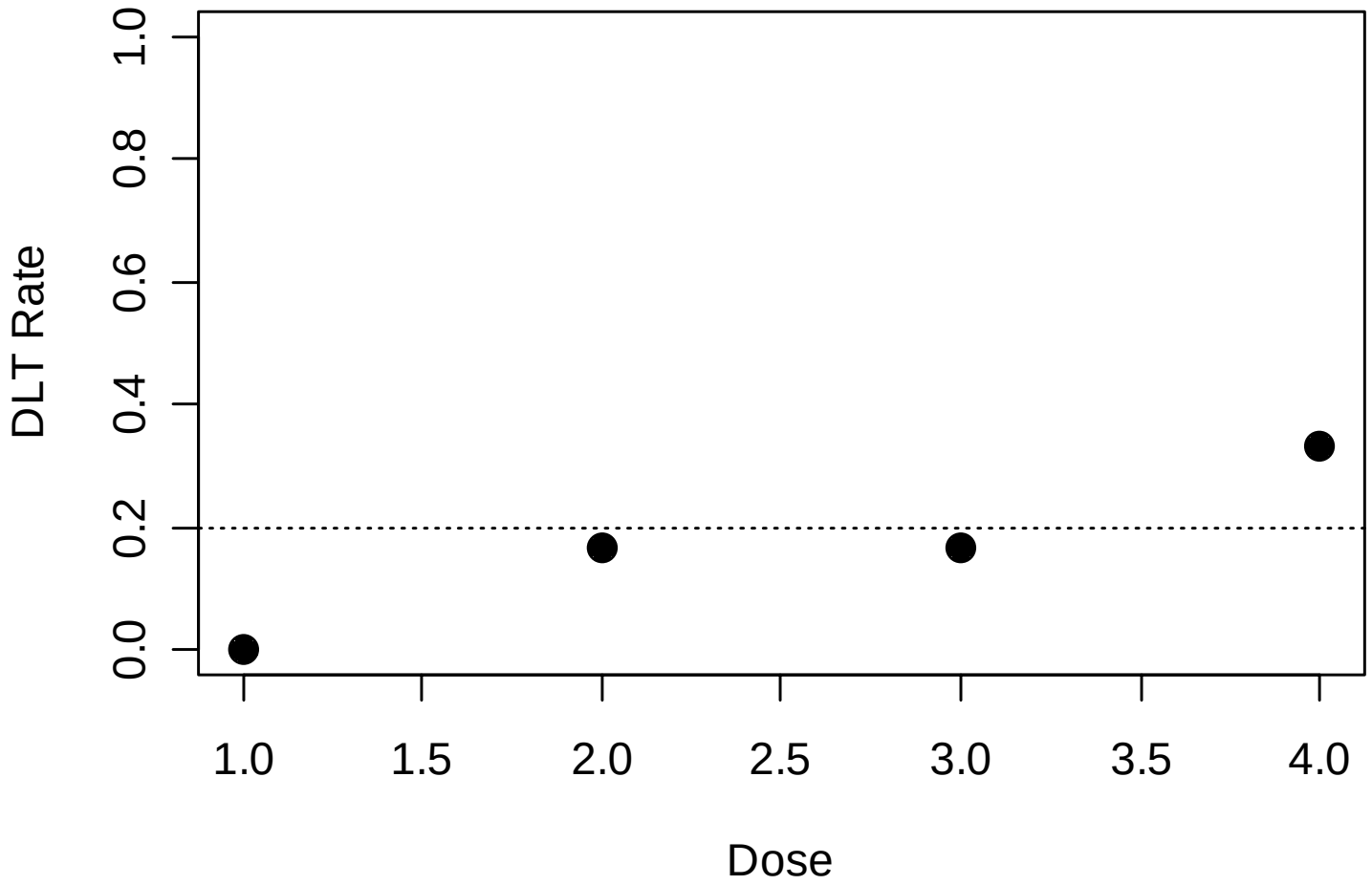
- **It is terribly imprecise and inaccurate in its estimate of the MTD**
- **Why?**
  - **MTD is not based on all of the data**
  - **Algorithm-based method**
  - **Ignores rate of toxicity!!!**
- Likely outcomes:
  - Choose a dose that is too high
    - Find in phase II that agent is too toxic.
    - Abandon further investigation or go back to phase I
  - Choose a dose that is too low
    - Find in phase II that agent is ineffective
    - Abandon agent

Two examples:

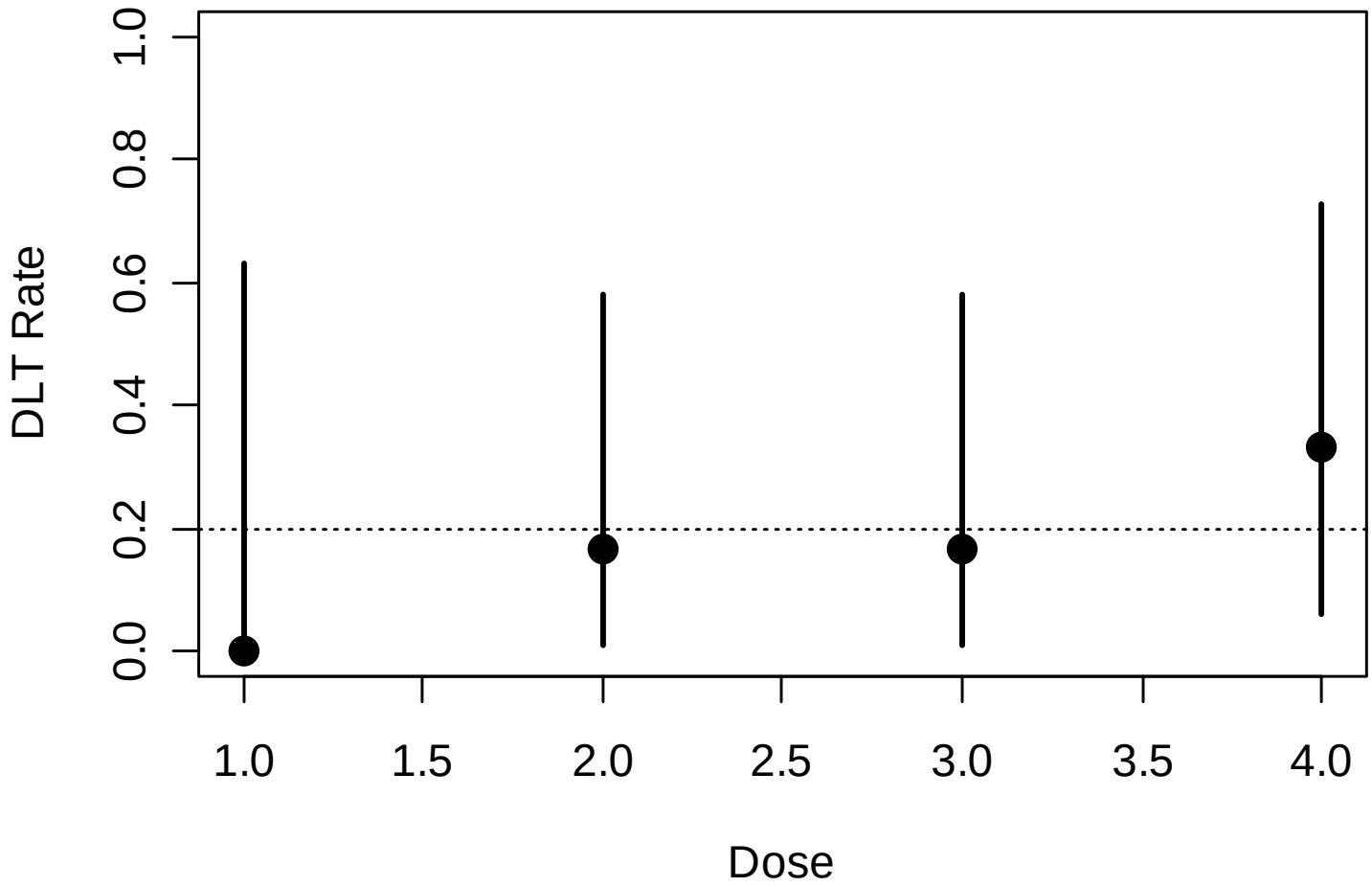
Example 1: total N=21

	Cohort 1	Cohort 2	Cohort 3	Cohort 4	Cohort 5	Cohort 6	Cohort 7
Dose	1	2	2	3	3	4	4
DLTs	0/3	1/3	0/3	1/3	0/3	1/3	1/3

Observed Data



Observed Data: with 90% CIs

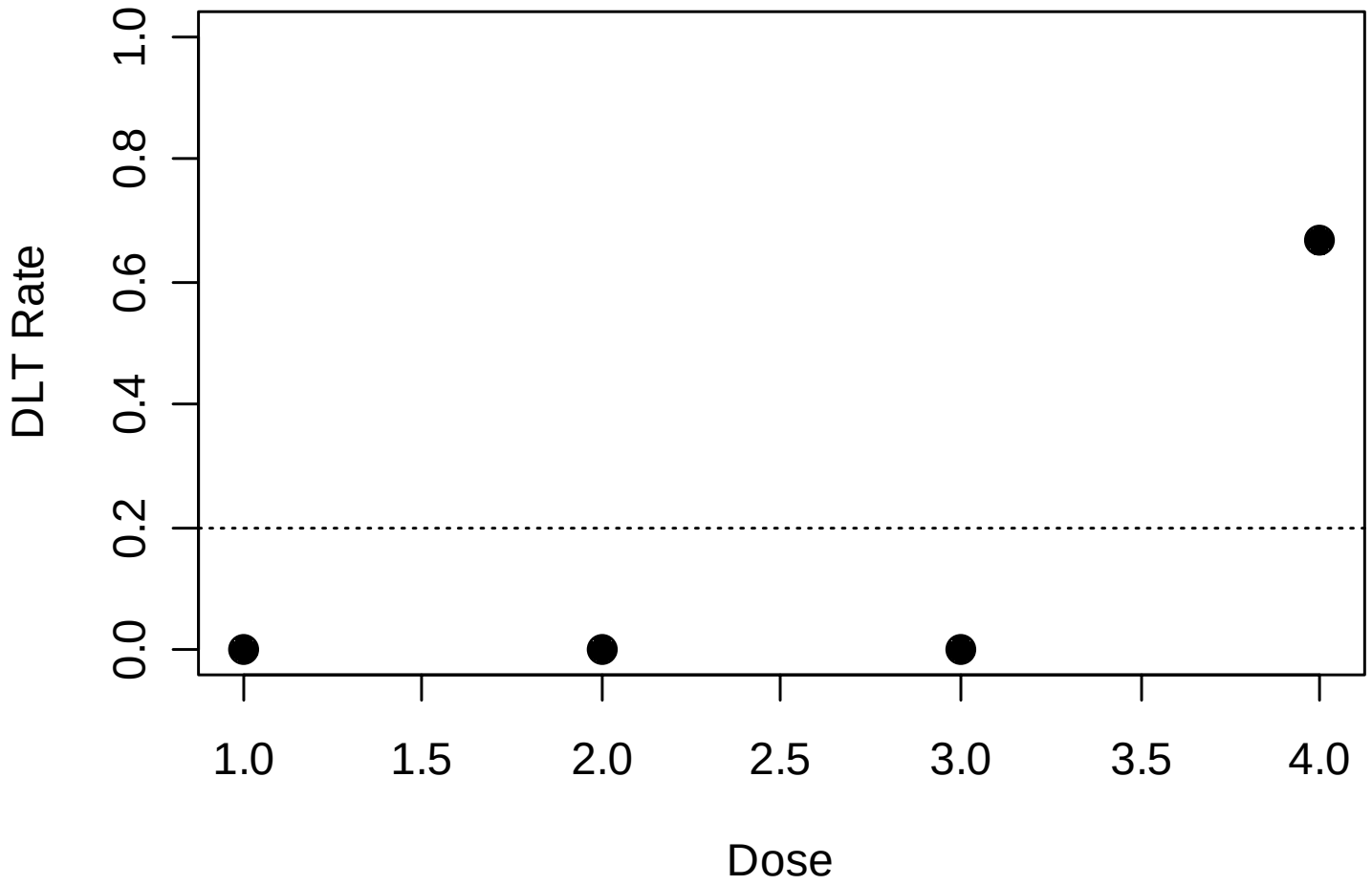


Example 2:

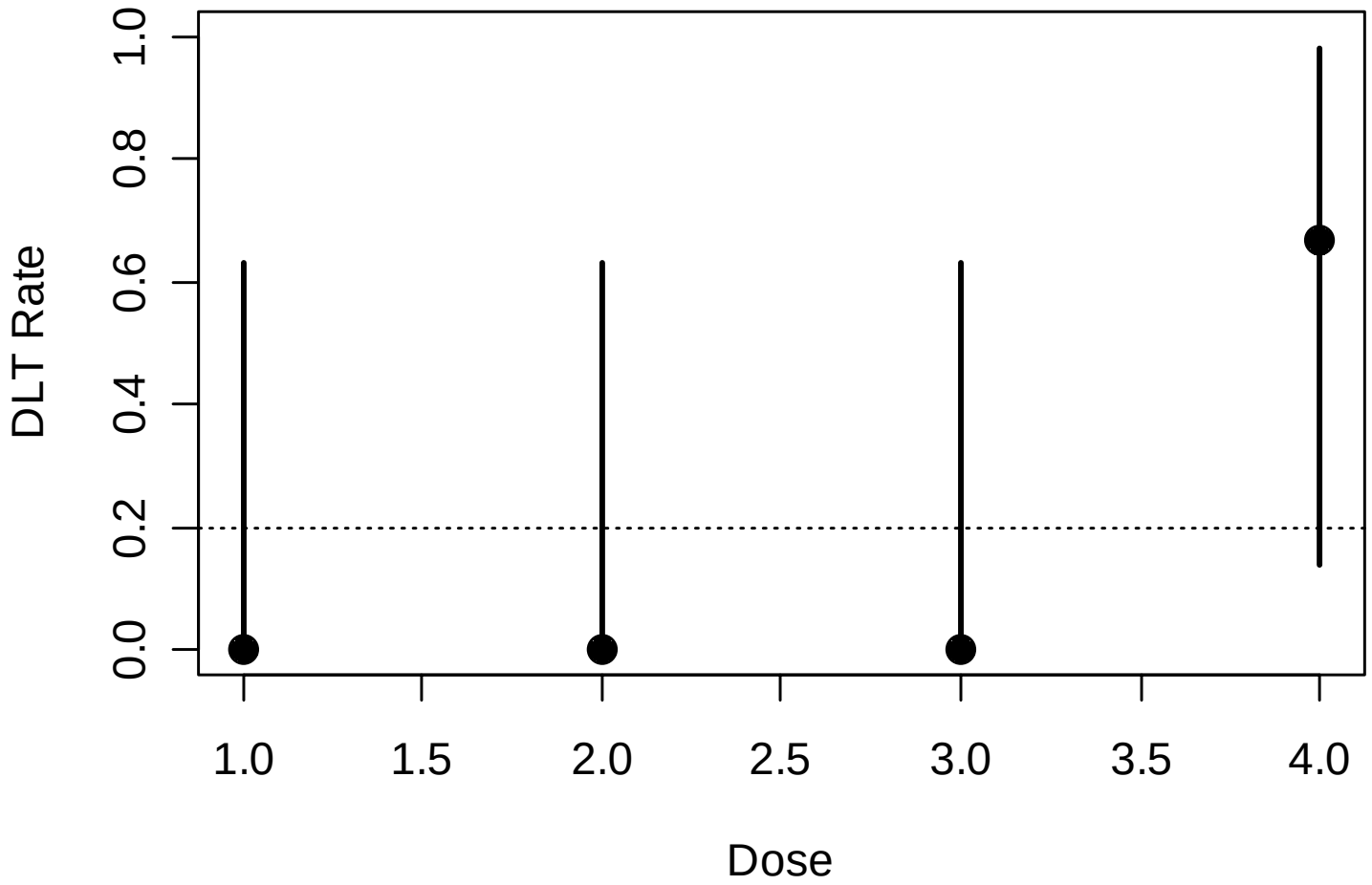
Example 2: total N=12

	Cohort 1	Cohort 2	Cohort 3	Cohort 4
Dose	1	2	3	4
DLTs	0/3	0/3	0/3	2/3

Observed Data



Observed Data: with 90% CIs



Why is the 3+3 so popular?

- People know how to implement it
- “we just want a quick phase I”
- It has historic presence
- FDA (et al.) accept and promote it
- There is a level of comfort from the approach
- The “better” approaches are too statistical(!)

USE A SMARTER DESIGN!

- **Phase I is the most critical phase of drug development!**
- **What makes a good design?**
  - Accurate selection of MTD
    - dose close to true MTD
    - dose has DLT rate close to the one specified
  - Relatively few patients in trial are exposed to toxic doses
- **Why not impose a statistical model?**
- **What do we "know" that would help?**
  - **Monotonicity**
  - **Desired level of DLT**

Continual Reassessment Method (CRM)

- Allows statistical modeling of optimal dose: dose-response relationship is assumed to behave in a certain way
- Can be based on “safety” or “efficacy” outcome (or both).
- Design searches for best dose **given a desired toxicity or efficacy level** and does so in an efficient way.
- **This design REALLY requires a statistician throughout the trial.**
- **ADAPTIVE**

CRM history in brief

- Originally devised by O'Quigley, Pepe and Fisher (1990) **where dose for next patient was determined based on responses of patients previously treated in the trial**

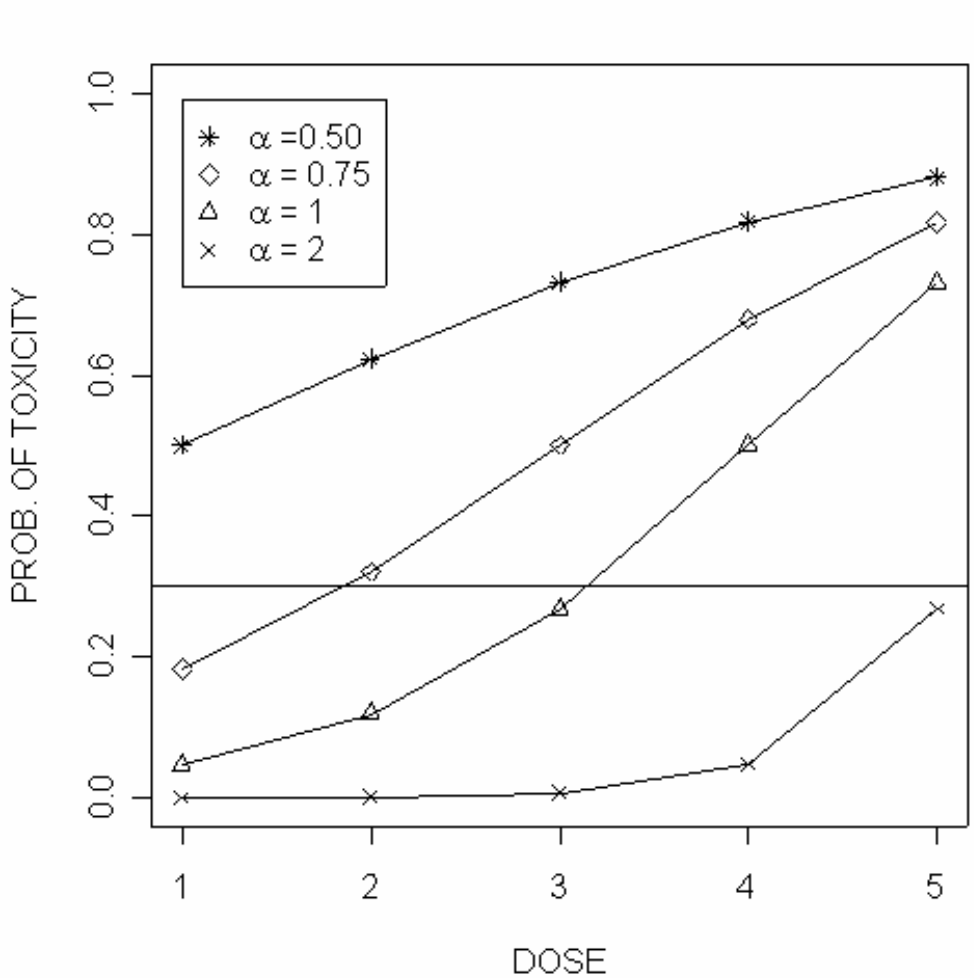
- Due to safety concerns, several authors developed variants
  - Modified CRM (Goodman et al. 1995)
  - Extended CRM [2 stage] (Moller, 1995)
  - Restricted CRM (Moller, 1995)
  - and others….

Some reasons why to use CRM

Table 4 Characteristics of five Phase 1 studies. Designs 1–3 are CRM designs with different sample sizes and cohort sizes. Designs 4–6 are "3 + 3" designs with different prespecified dose levels. All six designs have the same true model of dose–toxicity. Dose levels for the "3 + 3" designs are shown in Figure 5. Results are based on 1000 simulated trials for each design

		Design 1 (CRM) (Example 2)	Design 2 (CRM)	Design 3 (CRM)	Design 4 ("3 + 3")	Design 5 ("3 + 3")	Design 6 ("3 + 3")
1	Total sample size: fixed for CRMs, median for "3 + 3"	30	50	60	27	27	39
2	Patients per cohort	3	5	3	3	3	3
3	Number of cohorts fixed for CRMs, median for "3 + 3"	10	10	20	9	9	13
4	% of trials with recommended dose within 250 mg of true dose (1656 mg)	57%	72%	71%	41%	35%	32%
5	% of trials with recommended dose within 400 mg of true dose (1656 mg)	80%	91%	89%	41%	54%	58%
6	% of trials with recommended dose dose-limiting toxicity rate of >40%	9.5%	5.8%	5.9%	7.1%	21%	12%
7	% of trials with recommended dose dose-limiting toxicity rate of >50%	0.9%	0.2%	0.6%	7.1%	2.0%	0.6%
8	% of trials with recommended dose dose-limiting toxicity rate of <20%	13%	5.7%	6.2%	52%	44%	38%
9	% of trials with recommended dose dose-limiting toxicity rate of <10%	0.0%	0.1%	0.0%	11%	16%	6.9%
10	Average % of patients treated at doses with 40% or greater dose-limiting toxicity rate	7.6%	7.8%	5.7%	17%	23%	7.5%
11	Average % of patients treated at doses with 20% or less dose-limiting toxicity rate	32%	19%	24%	62%	53%	64%
12	Average % of patients with dose-limiting toxicities	26%	28%	26%	21%	22%	19%

Basic Idea of CRM



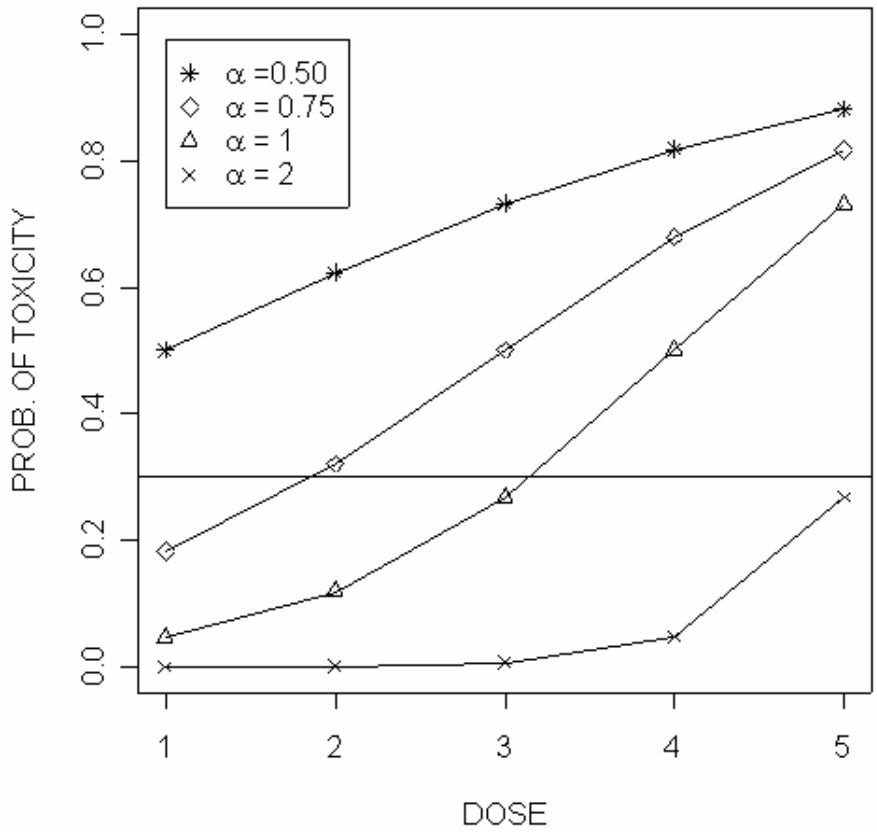
$$p(toxicity|dose = d_i) = \frac{\exp(3 + \alpha d_i)}{1 + \exp(3 + \alpha d_i)}$$

Modified CRM

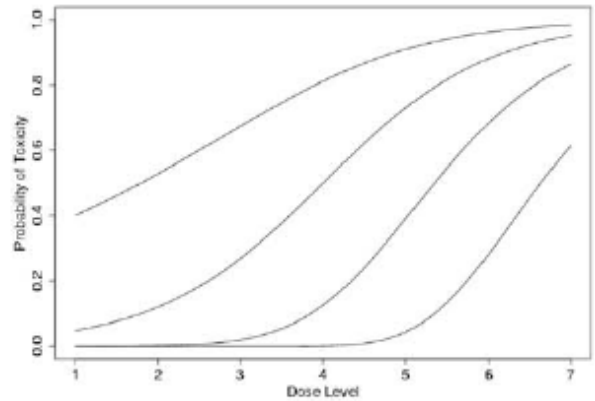
(Goodman, Zahurak, and Piantadosi, Statistics in Medicine, 1995)

Carry-overs from standard CRM

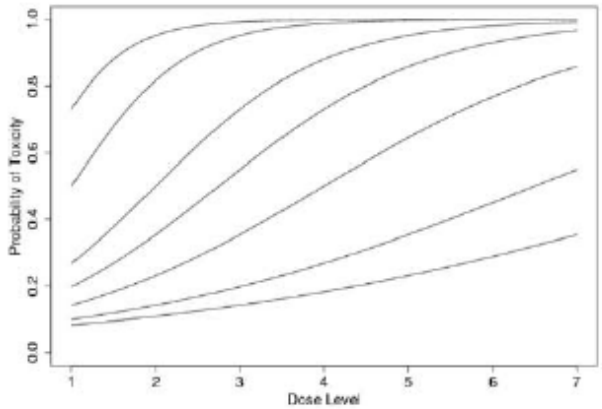
- Mathematical dose-toxicity model must be assumed
- To do this, need to think about the dose-response curve and get preliminary model.
- **We CHOOSE the level of toxicity that we desire for the MTD (e.g., p = 0.30)**
- At end of trial, we can estimate dose response curve.



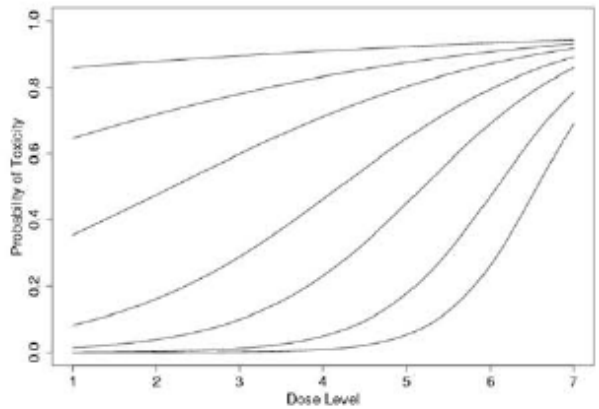
Some other mathematical models we could choose



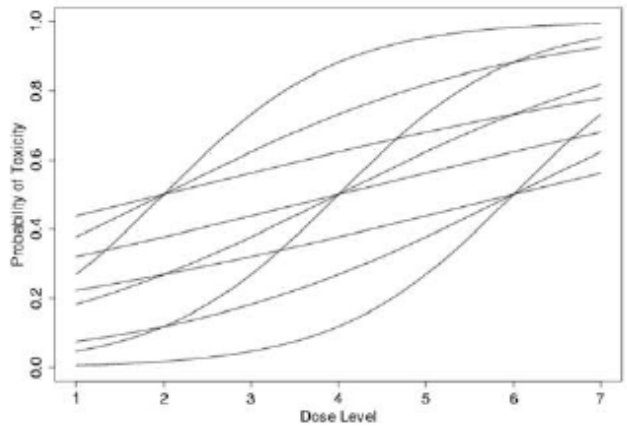
A. Hyperbolic tangent: $p(dose) = \left(\frac{\tanh(dose) + 1}{2} \right)^{b}$



B. One-parameter logistic: $p(dose) = \frac{e^{-4+b \cdot dose}}{1 + e^{-4+b \cdot dose}}$



C. One-parameter logistic: $p(dose) = \frac{e^{3+b \cdot dose}}{1 + e^{3+b \cdot dose}}$



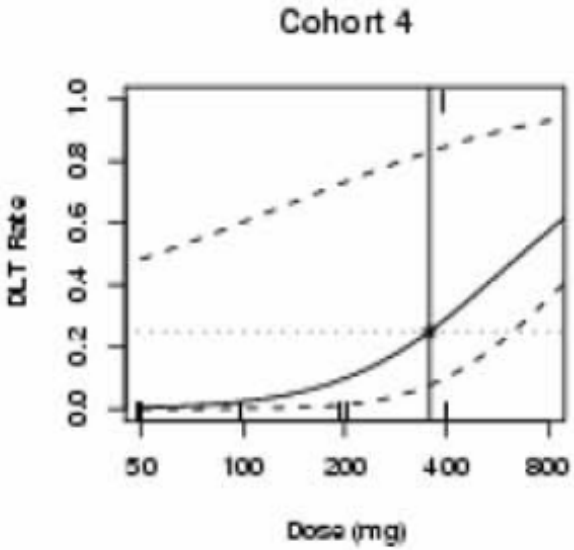
D. Two-parameter logistic: $p = \frac{e^{a+b \cdot dose}}{1 + e^{a+b \cdot dose}}$

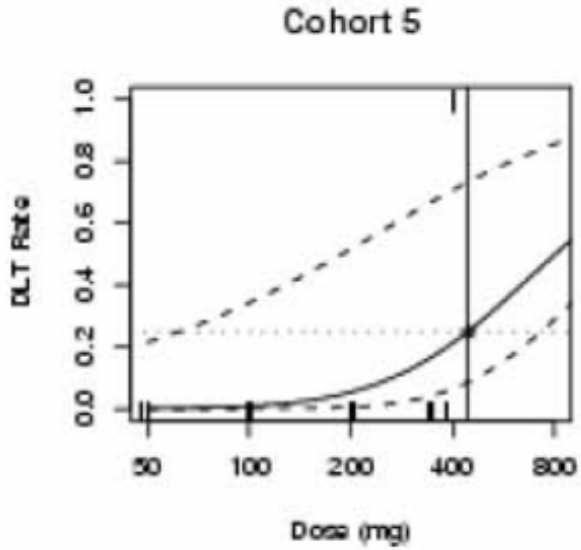
Modified CRM by Goodman, Zahurak, and Piantadosi (Statistics in Medicine, 1995)

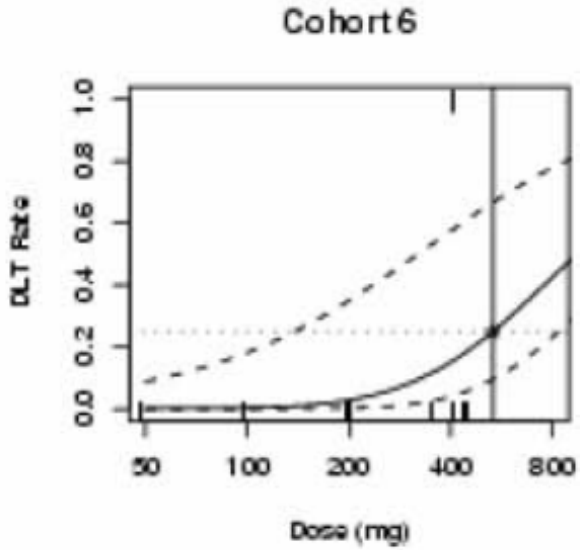
- Modifications by Goodman et al.
  - Use 'standard' dose escalation model until first toxicity is observed:
    - Choose cohort sizes of 1, 2, or 3
    - Use standard '3+3' design (or, in this case, '2+2')
  - **Upon first toxicity, fit the dose-response model using observed data**
    - Estimate α
    - Find dose that is closest to desired toxicity rate.
  - Does not allow escalation to increase by more than one dose level.
  - De-escalation can occur by more than one dose level.

Simulated Example

- Shows how the CRM works in practice
- Assume:
  - Cohorts of size 2
  - Escalate at fixed doses until DLT occurs
  - Then, fit model and use model-based escalation
  - Increments of 50mg are allowed
  - Stop when 10 patients have already been treated at a dose that is the next chosen dose


Cohort 4
DLT Rate
0.0 0.2 0.4 0.6 0.8 1.0
50 100 200 400 800
Dose (mg)


Cohort 5
DLT Rate
0.0 0.2 0.4 0.6 0.8 1.0
50 100 200 400 800
Dose (mg)


Cohort 6
DLT Rate
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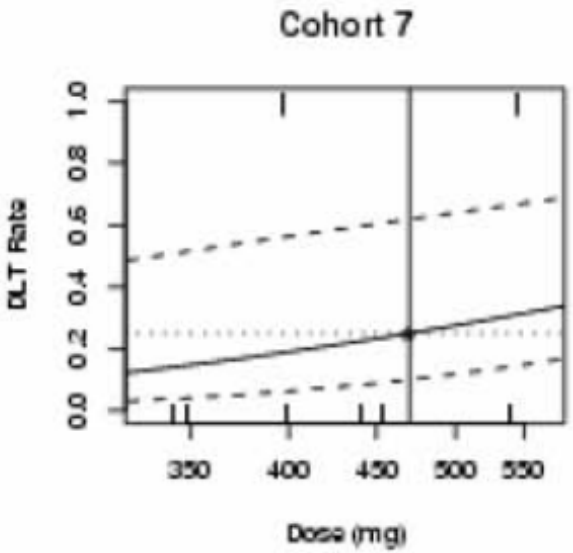
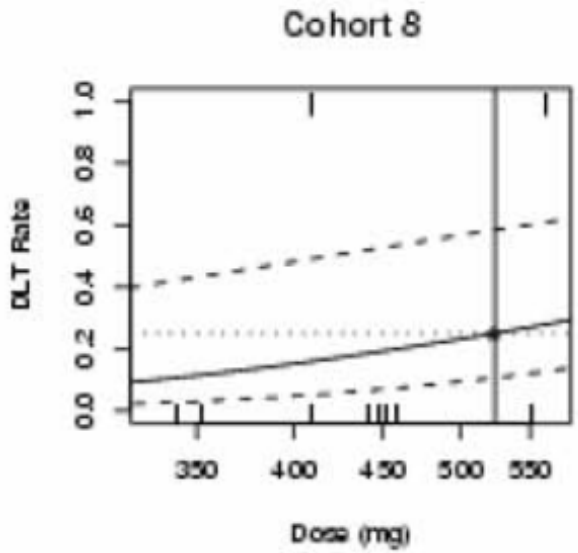
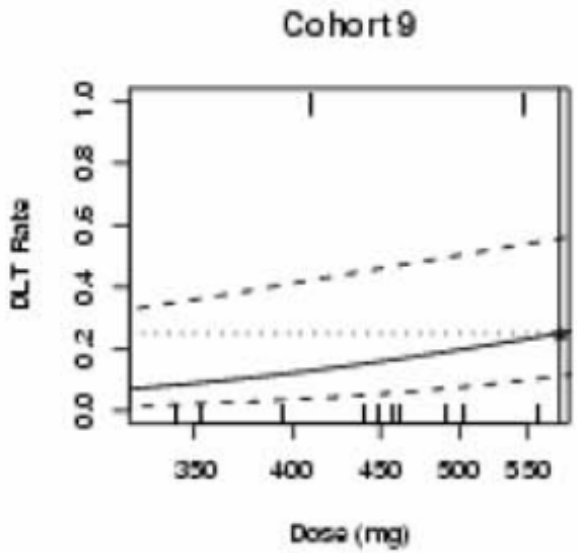
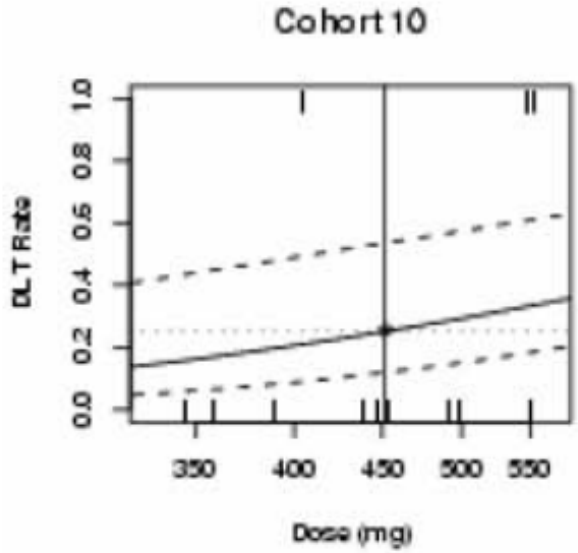
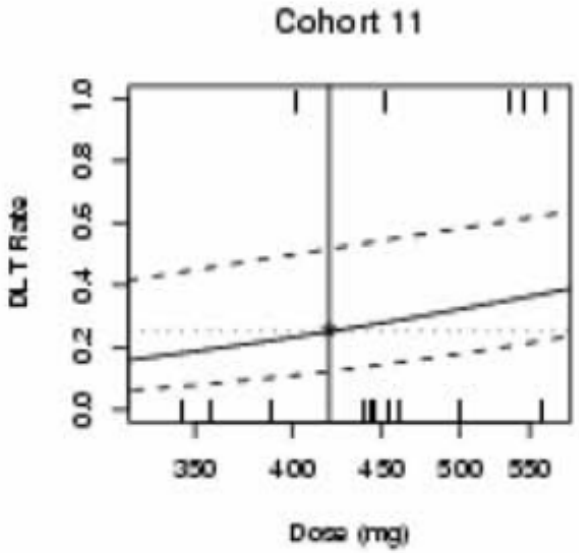
50 100 200 400 800
Dose (mg)


Cohort 7
DLT Rate
0.0 0.2 0.4 0.6 0.8 1.0
350 400 450 500 550
Dose (mg)


Cohort 8
DLT Rate
0.0 0.2 0.4 0.6 0.8 1.0
350 400 450 500 550
Dose (mg)


Cohort 9
DLT Rate
0.0 0.2 0.4 0.6 0.8 1.0
350 400 450 500 550
Dose (mg)


Cohort 10
DLT Rate
0.0
0.2
0.4
0.6
0.8
1.0
350
400
450
500
550
Dose (mg)


Cohort 11
DLT Rate
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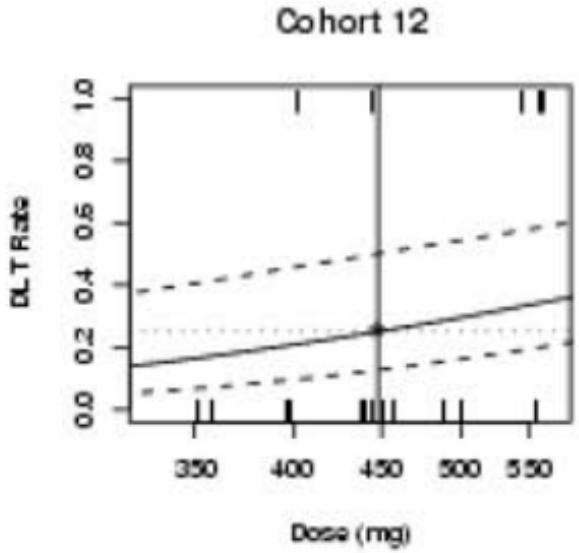
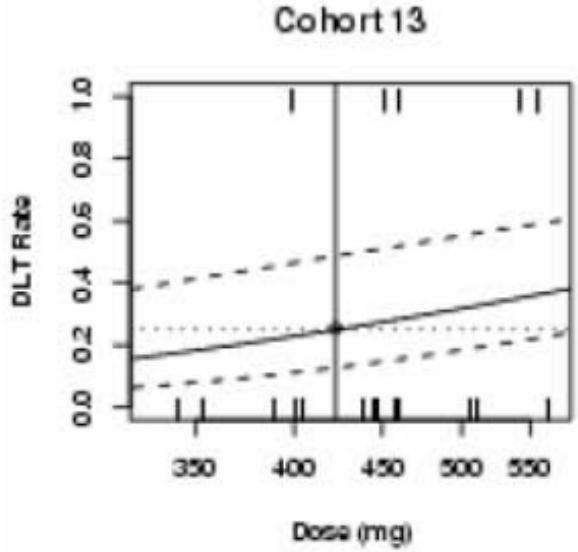
0.2
0.4
0.6
0.8
1.0
350
400
450
500
550
Dose (mg)


Cohort 12
DLT Rate
0.0
0.2
0.4
0.6
0.8
1.0
350
400
450
500
550
Dose (mg)


Cohort 13
DLT Rate
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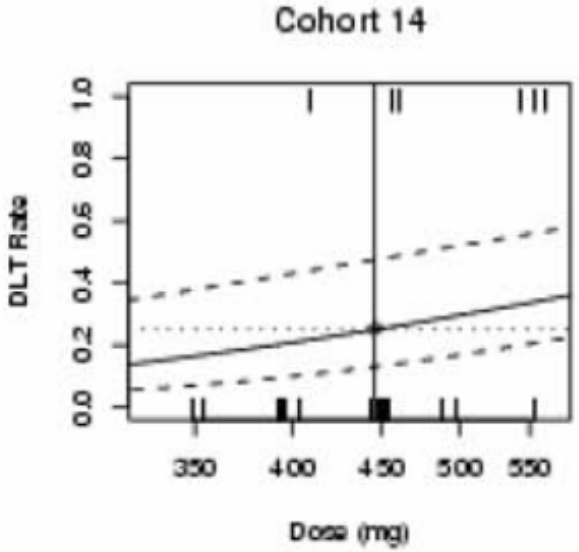
0.2
0.4
0.6
0.8
1.0
350
400
450
500
550
Dose (mg)


Cohort 14
DLT Rate
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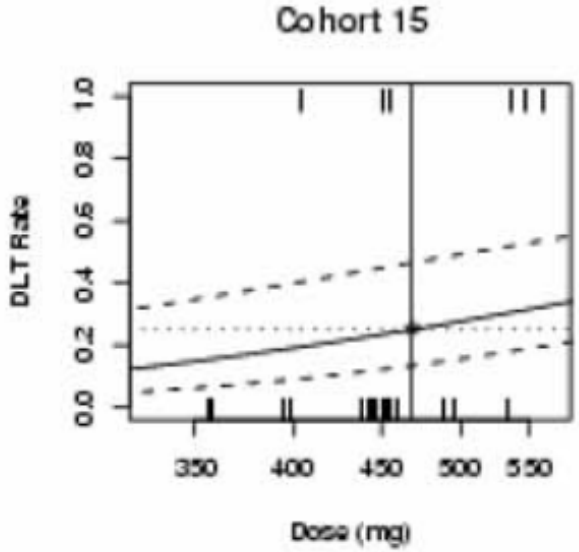
0.6
0.8
1.0
350
400
450
500
550
Dose (mg)


Cohort 15
DLT Rate
0.0
0.2
0.4
0.6
0.8
1.0
350
400
450
500
550
Dose (mg)

Result

- 450mg is determined to be the optimal dose to take to phase II
- 30 patients (?!)
- Confidence interval for true DLT rate at 450mg: 15% - 40%
- Used ALL of the data to make our conclusion

Real Example Samarium in pediatric osteosarcoma:

Desired DLT rate is 30%.

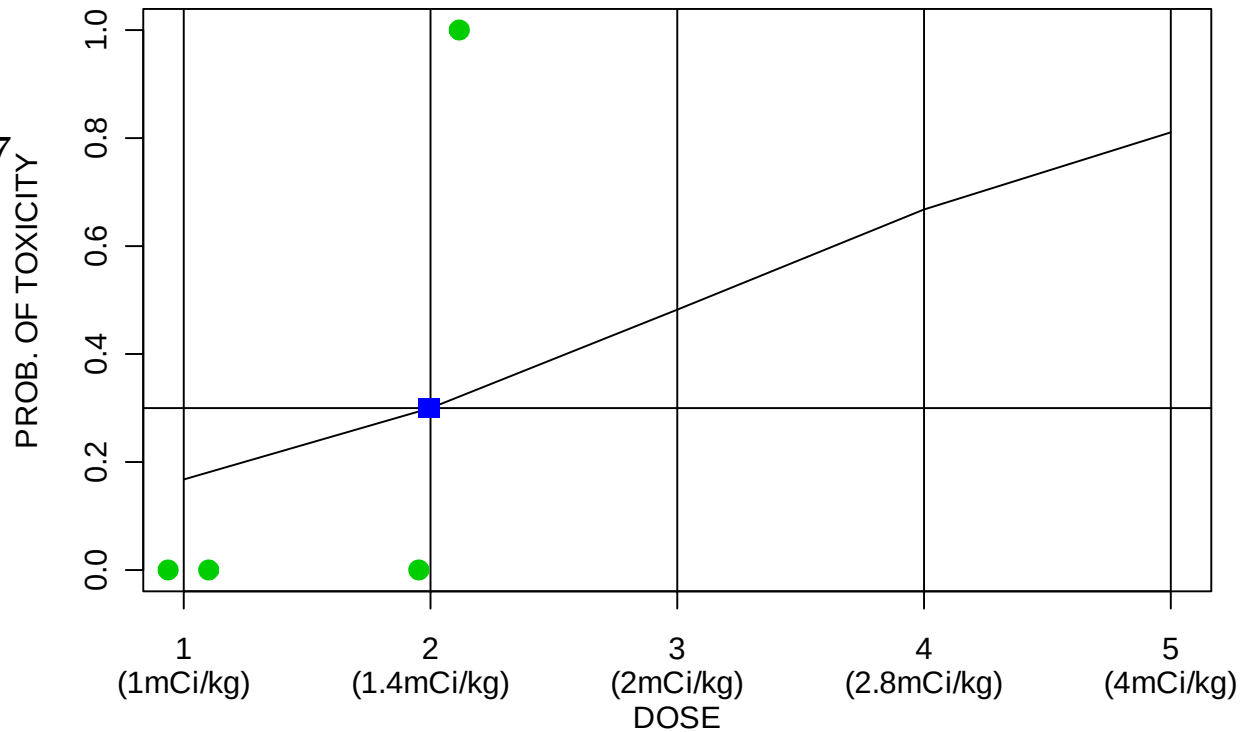
2 patients treated at dose 1 with 0 toxicities

2 patients treated at dose 2 with 1 toxicity

➔ Fit CRM using equation below

$$p(toxicity|dose = d_i) = \frac{\exp(3 + \alpha d_i)}{1 + \exp(3 + \alpha d_i)}$$

- Estimated α = 0.77
- Estimated dose is 1.4mCi/kg for next cohort.



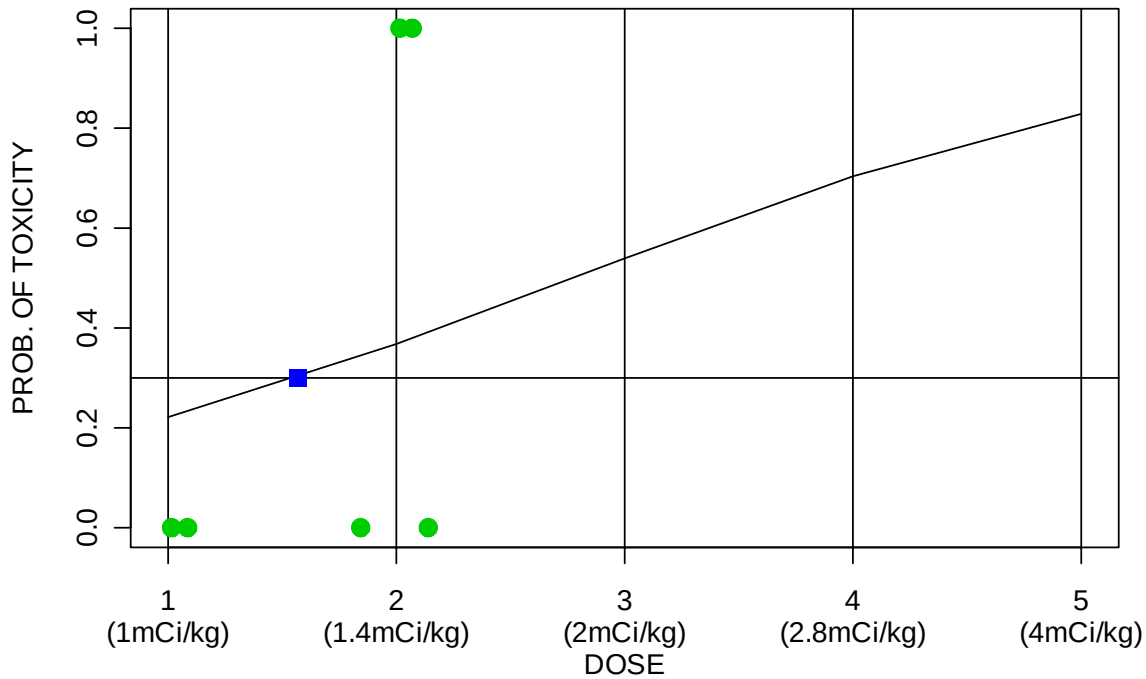
Example Samarium study with cohorts of size 2:

2 patients treated at 1.0 mCi/kg with no toxicities

4 patients treated at 1.4 mCi/kg with 2 toxicities

➔ Fit CRM using equation on earlier slide

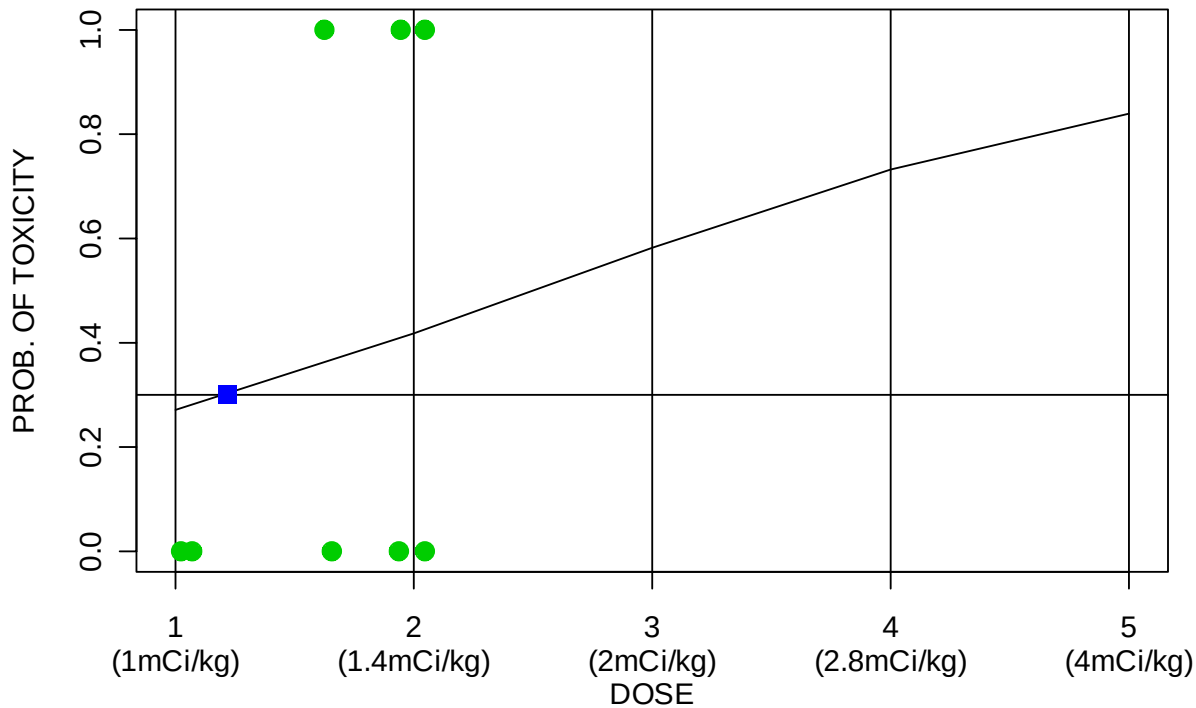
- Estimated $\alpha = 0.71$
- Estimated dose for next patient is 1.2 mCi/kg



Example Samarium study with cohorts of size 2:

2 patients treated at 1.0 mCi/kg with no toxicities
4 patients treated at 1.4 mCi/kg with 2 toxicities
2 patients treated at 1.2 mCi/kg with 1 toxicity
➔ Fit CRM using equation on earlier slide

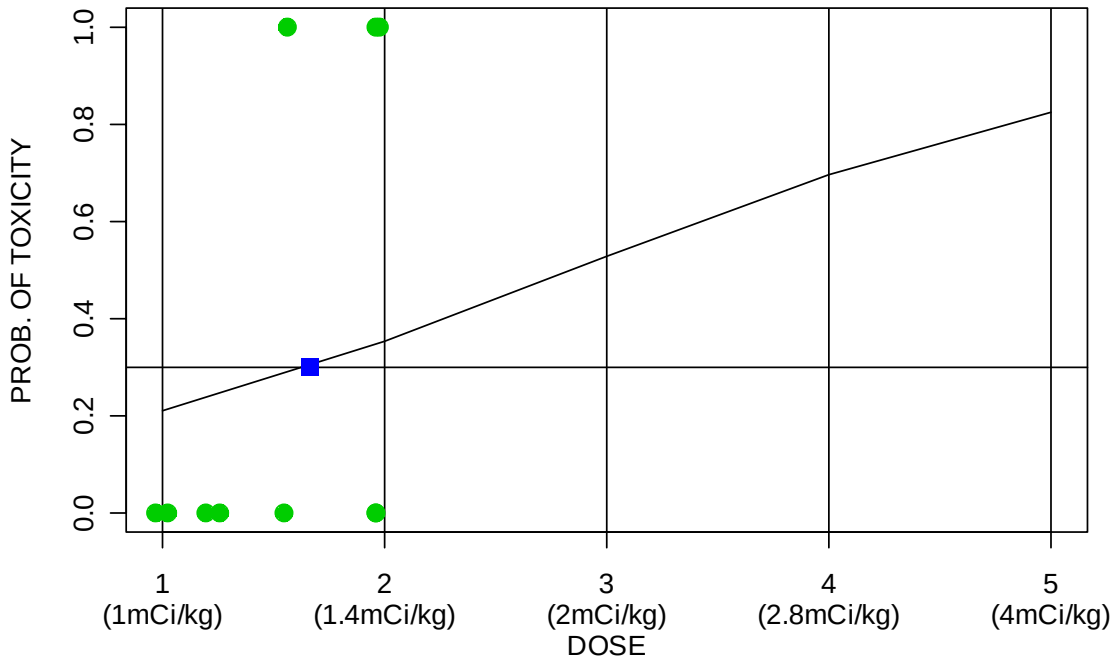
- Estimated $\alpha = 0.66$
- Estimated dose for next patient is 1.1 mCi/kg



Example Samarium study with cohorts of size 2:

2 patients treated at 1.0 mCi/kg with no toxicities
4 patients treated at 1.4 mCi/kg with 2 toxicities
2 patients treated at 1.2 mCi/kg with 1 toxicity
2 patients treated at 1.1 mCi/kg with no toxicities
➔ Fit CRM using equation on earlier slide

- Estimated $\alpha = 0.72$
- Estimated dose for next patient is 1.2 mCi/kg



When does it end?

- Pre-specified stopping rule
- Can be fixed sample size
- Often when a “large” number have been assigned to one dose.
- This study should enroll at least two more cohorts.

Dose increments

- Can be discrete or continuous
- Infusion?
- Tablet?
- Stopping rule should depend on nature (and size) of allowed increment!

A little more on the statistics:

- Original design was purely Bayesian
- Requires a prior distribution
  - Prior is critically important because it outweighs the data early in the trial
  - Computationally is somewhat challenging
- Some revised designs use ML
  - Simpler to use
  - Once a DLT is observed, model can be fit
  - Some will “inform” the ML approach using “pseudo-data” (Piantadosi)

Simple prediction, but backwards(?)

- Usual prediction:
  - Get some data
  - Fit model
  - Estimate the **outcome** for a new patient with a particular **characteristic**
- CRM prediction
  - Get some data
  - Fit model
  - Find the **characteristic** (dose) associated with a particular **outcome** (DLT rate)

Finding the next dose: ML approach

- Use maximum likelihood to estimate the model.
- What likelihood do we use? Binomial.

$$L(p; y) = \prod_{i=1}^{N} p^{y_i} (1 - p)^{(1-y_i)}$$

$$p(toxicity | dose = d_i) = \frac{\exp(3 + \alpha d_i)}{1 + \exp(3 + \alpha d_i)}$$

- Algorithmic estimation of α

Finding next dose

- Recall model, now with estimated α:

$$p_i = \frac{\exp(3 + \hat{\alpha} d_i)}{1 + \exp(3 + \hat{\alpha} d_i)}$$

- Rewrite in terms of d_i:

$$d_i = \frac{\log(\frac{p_i}{1 - p_i}) - 3}{\hat{\alpha}}$$

Finding next dose

- Use desired DLT rate as p_i

$$d_i = \frac{\log(\frac{3}{7}) - 3}{\hat{\alpha}} = \frac{-3.85}{\hat{\alpha}}$$

Negative dose?

- Doses are often mapped to another scale
- dose coding:

  -6 = level 1 (1.0)

  -5 = level 2 (1.4)

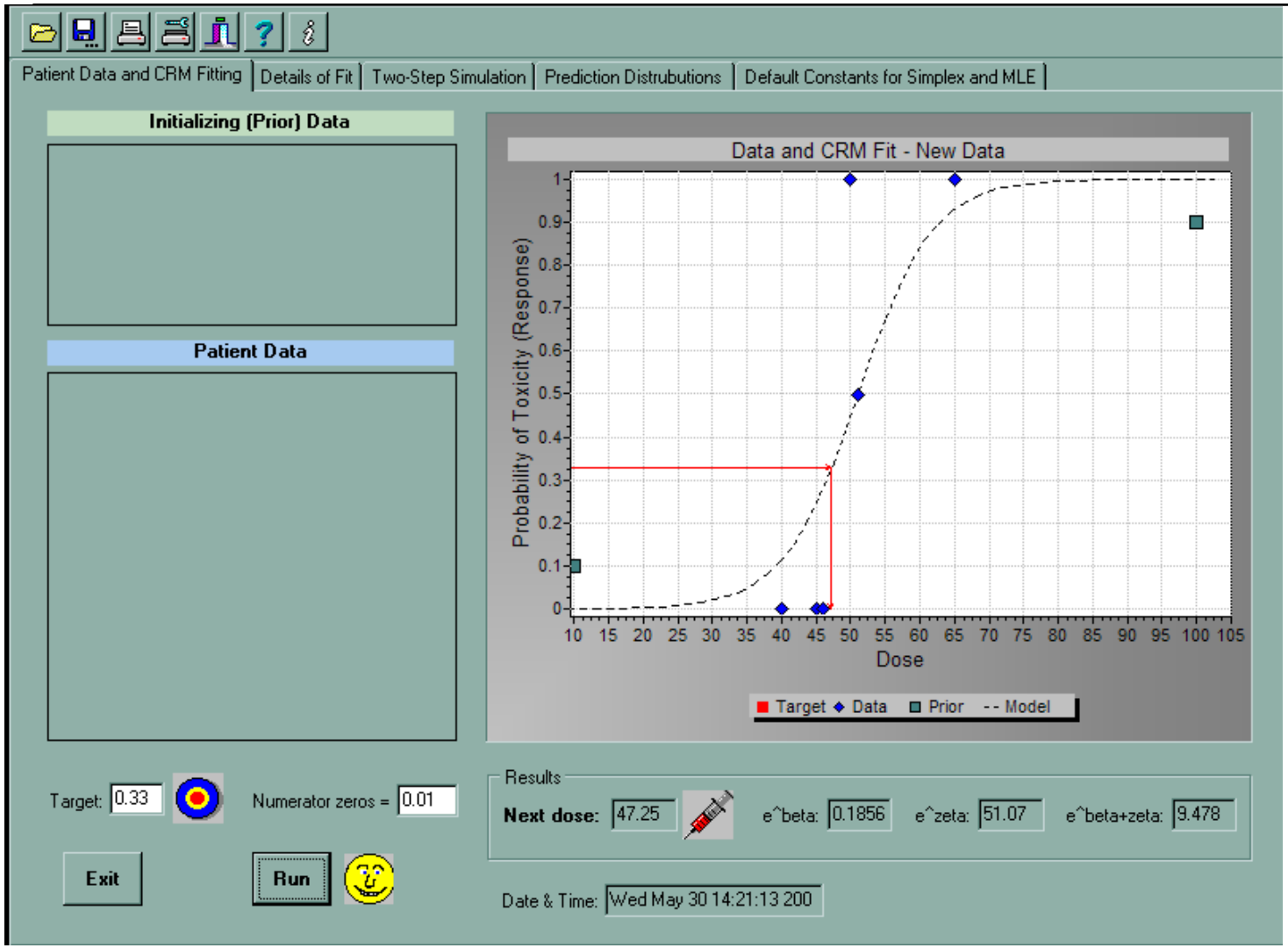
  -4 = level 3 (2.0)

  -3 = level 4 (2.8)

  -2 = level 5 (4.0)
- WHY? Makes the statistics work….

CRM Software:

http://www.cancerbiostats.onc.jhmi.edu/software.cfm



Escalation with Overdose Control

- EWOC (Babb et al.)
- Similar to CRM
- Bayesian
- Advantage: overdose control
  - "loss function"
  - Constrained so that the predicted proportion of patients who receive an overdose cannot exceed a specified value
  - **Implies that giving an overdose is greater mistake than an underdose**
  - CRM does not make this distinction
  - This control is changed as data accumulates

Figure 3. Proportion of patients given doses for which the probability of a severe toxic reaction is less than or equal to 1/5. Each × and + represents the results from all simulation runs for a particular parameter combination. Each point, (●), is the average of the results obtained for a particular method at the six parameter combinations considered. For each of the UD schemes the results obtained when only 6 dose levels were used are shown to the left of the results obtained when 11 levels were used

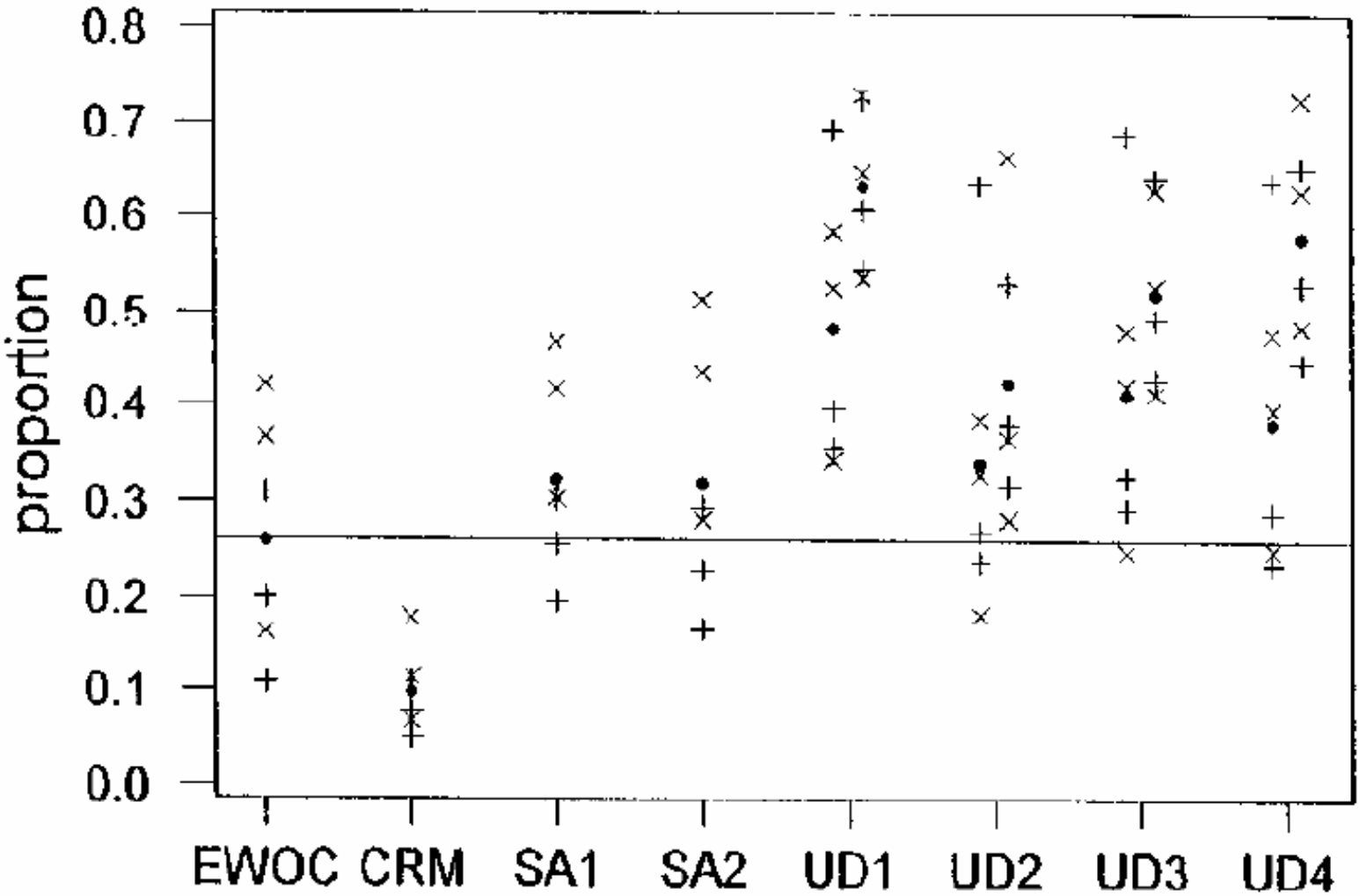


Figure 9. Average bias of $\hat{\gamma}$, the estimate of the MTD

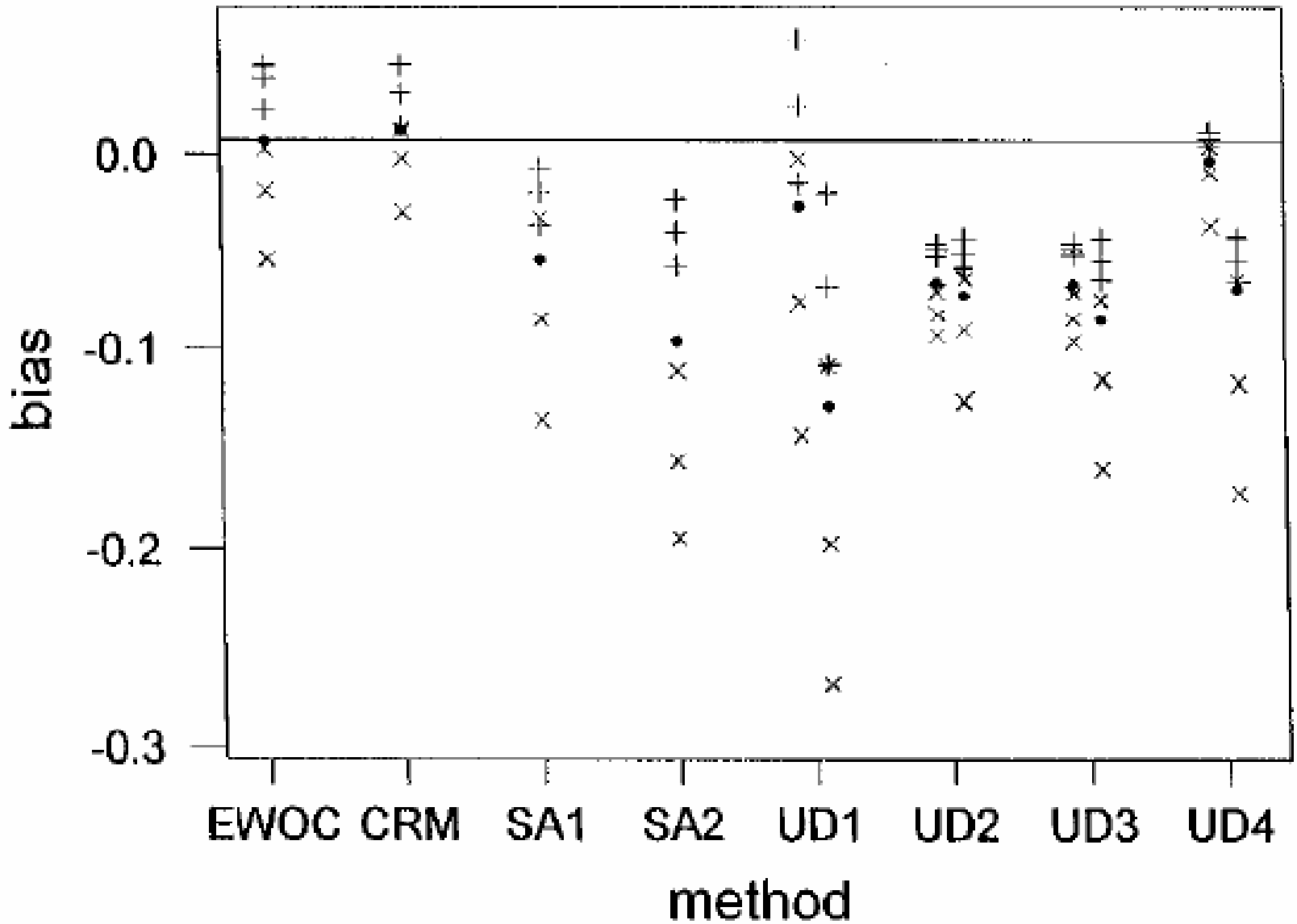
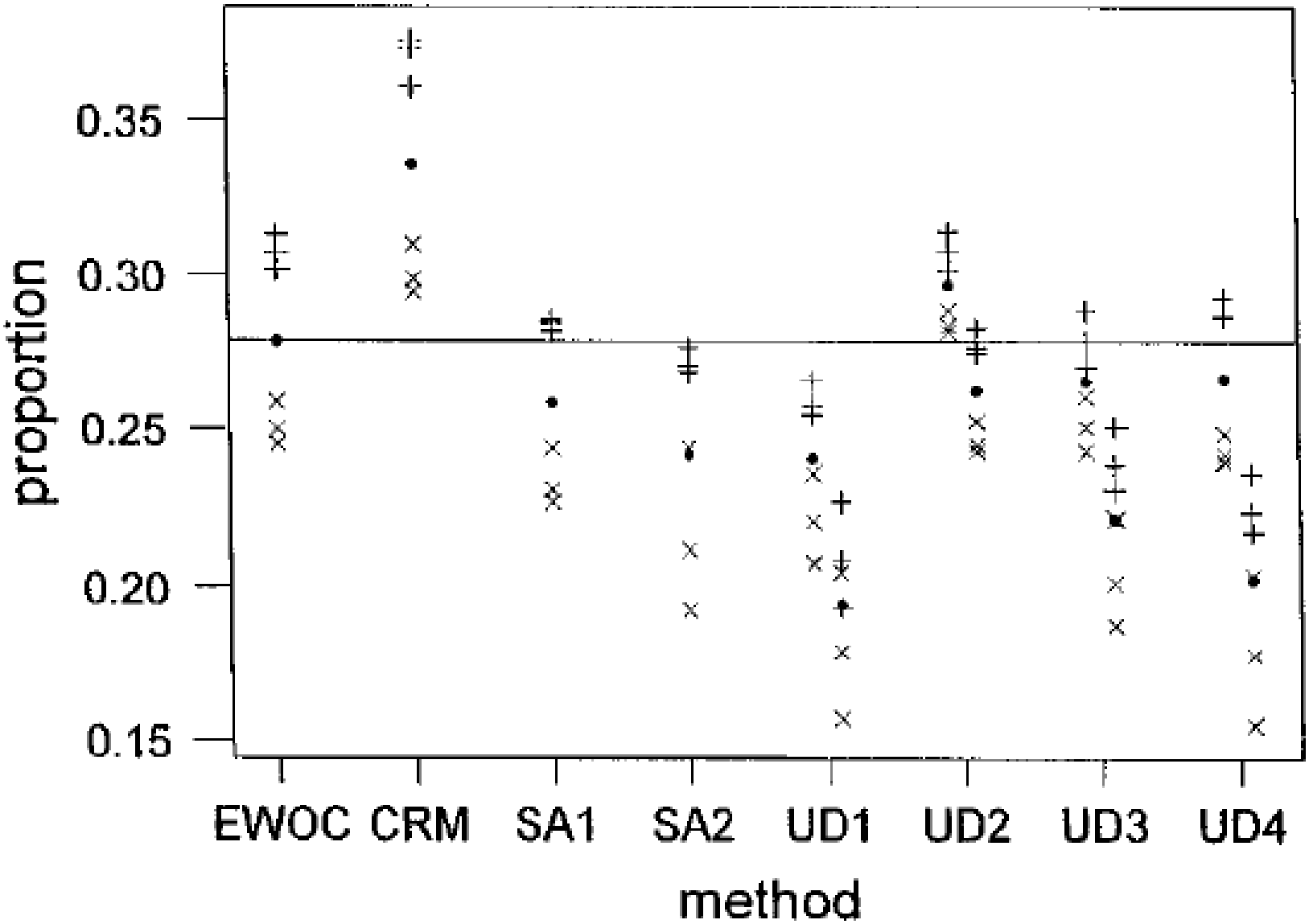
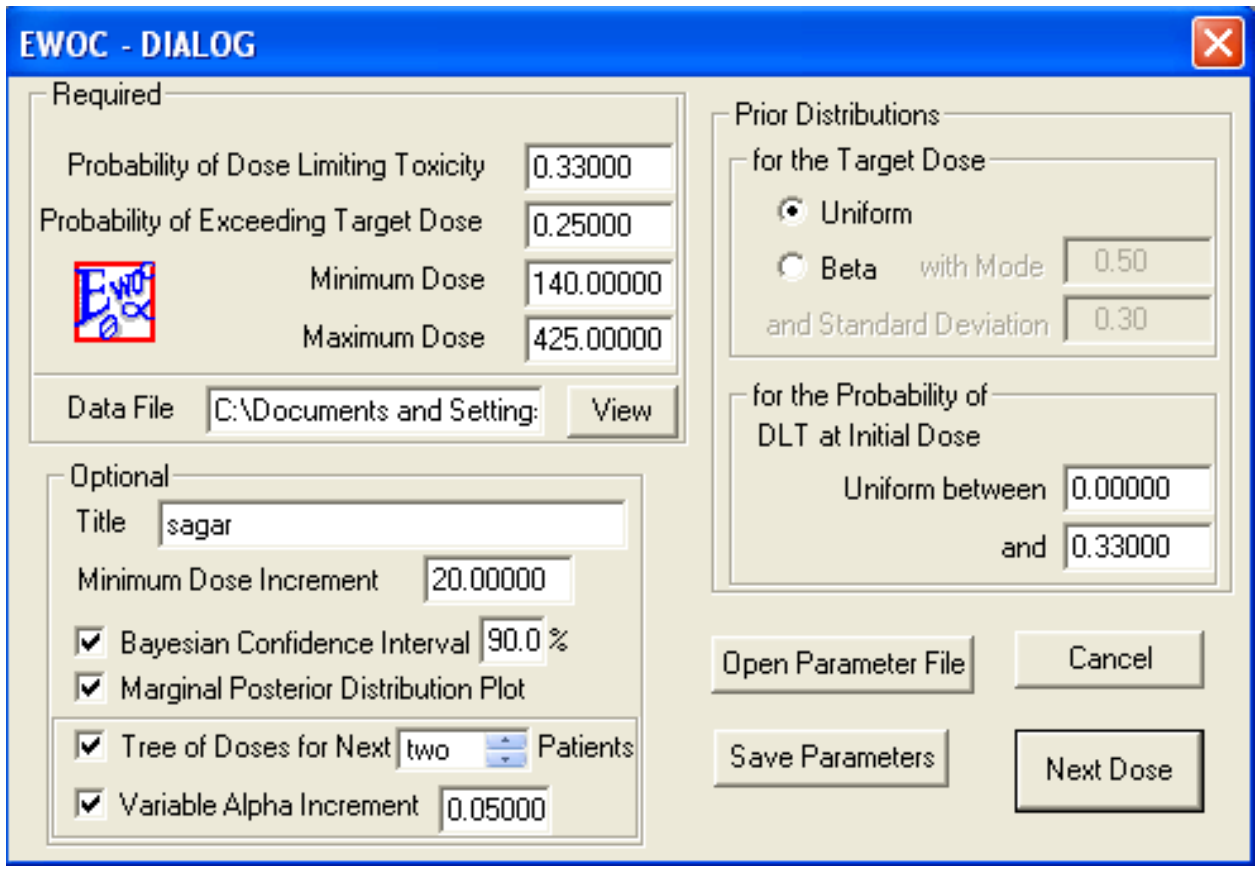


Figure 12. Proportion of patients exhibiting dose-limiting toxicity



EWOC Software

- http://www.sph.emory.edu/BRI-WCI/ewoc.html



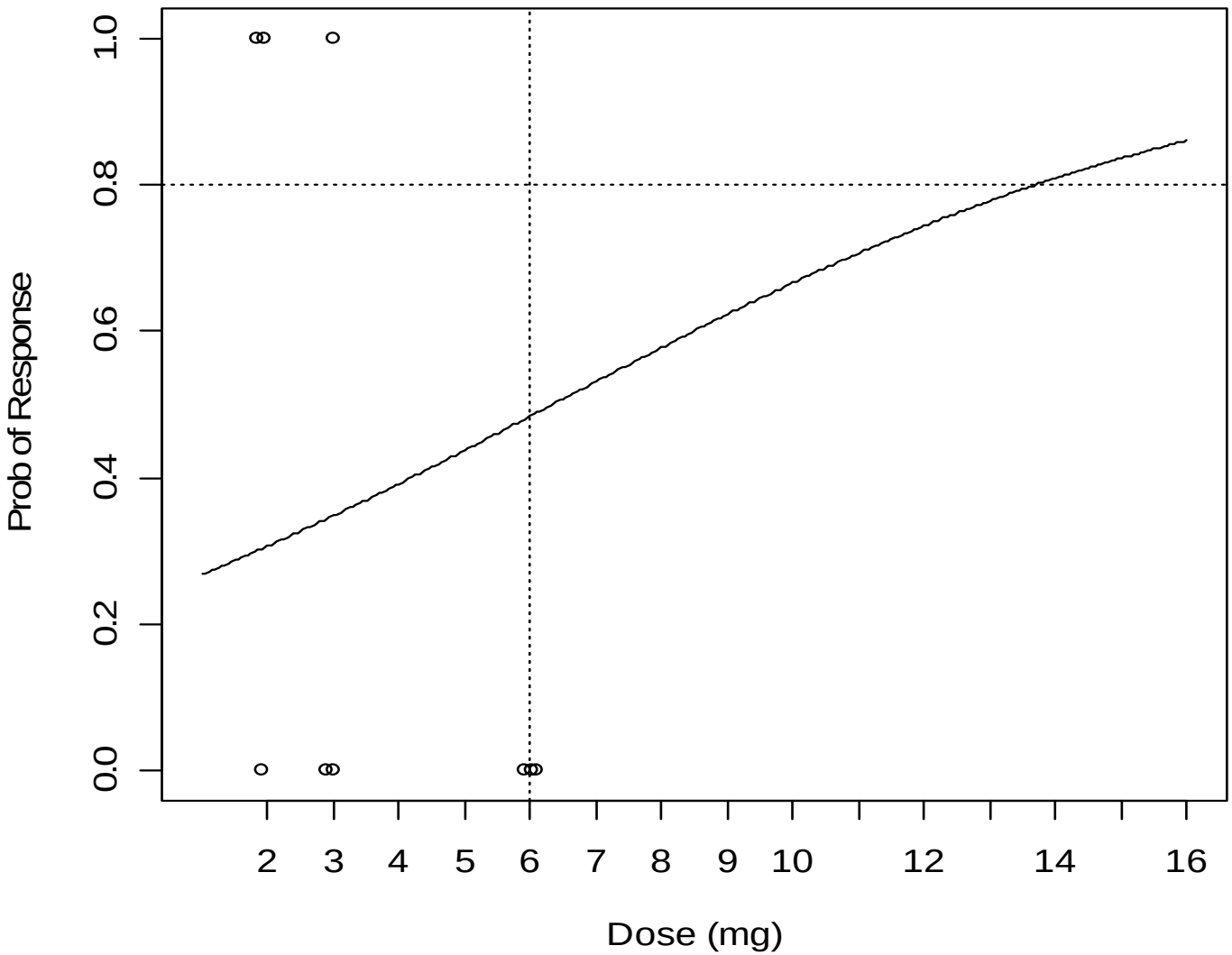
Other Novel Ideas in Phase I

- Outcome is not always toxicity
- Even in phase I, efficacy can be outcome to guide dose selection
- Two outcomes: safety and efficacy

Efficacy Example: Rapamycin in Pancreatic Cancer

- Outcome: response
- Response = 80% inhibition of pharmacodynamic marker
- Assumption: as dose increases, % of patients with response will increase
- Desired proportion responding: 80%

Efficacy Example: Rapamycin in Pancreatic Cancer



Safety and Efficacy

- Zhang, Sargent, Mandrekar
- Example: high dose can induce “over-stimulation”
- Three categories:
  - 1 = no response, no DLT
  - 2 = response, no DLT
  - 3 = DLT
- Use the continuation ratio model
- Very beautiful(!)
- Not particularly friendly at the current time for implementation

Safety and Efficacy

- I'm working on less beautiful, more practical approach
- Y = 1 if toxicity
  = 0 if no toxicity
- Z = 1 if efficacy
  = 0 if no efficacy
- Simultaneously search for doses with constraints based on toxicity

Summary: “Novel” Phase I trials

- Offer significant improvements over “traditional” phase I design
  - Safer
  - More accurate
- Slightly larger phase I: worth it!
- Related methods: Bayesian Adaptive

Why isn't everyone using these?

- Change in paradigm
- Larger N
- "I just want a quick phase I"
- Large investment of time from statistician
- Need time to "think" and plan it.
- IRB and others (e.g. CTEP) worry about safety (unjustified!)

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