

Methods for the estimation of cancer survival

The proportion of people alive at a specified time following diagnosis with cancer is the **absolute or observed survival**:

$$S(t) = e^{-\int h(t)dt}$$

where S is the decaying proportion of patients alive after t , the time since diagnosis, and $h(t)$ is the hazard function, or the death rate of patients until t . The hazard is usually high shortly after diagnosis and smaller at later intervals, giving rise to more steeply decaying survival curves early after diagnosis.

$S(t)$ and $h(t)$ are estimated from Swiss data using the STATA™ command `strs v1.4.2.2 (16.4.2017)` in consecutive intervals after diagnosis of increasing length, assuming constant hazard within intervals¹. Cut points were set to 0.1, 0.2, 0.6, 1, 2, 3, ..., 10 years after diagnosis.

Absolute or observed survival proportions are not well suited for comparisons because they depend heavily on patient characteristics such as age at diagnosis or comorbidities, in addition to other risk factors. It is more informing to assess the ability of patients to survive their cancer by considering only deaths due to the cancer in question, and to treat deaths due to other causes as censored (i.e. incomplete) observations, which is called **cause-specific survival**.

Because it can be difficult to agree the underlying main cause of death, another approach is usually adopted: the **relative survival**. Relative survival is the ratio of observed survival of cancer patients and expected survival of a group of persons from the general population, who are identical with the group of cancer patients with respect to the potential risk factors such age, sex, calendar year and region of residence:

$$R(t) = \frac{S(t)}{S^*(t)}$$

with $R(t)$ as relative survival, $S(t)$ as the observed survival, $S^*(t)$ as the expected survival, and t as the time since diagnosis. The expected survival is derived from population lifetables according to the Ederer_II method². 50% relative survival signifies that cancer patients survived half as well as their counterparts in the general population. The surplus mortality can be assigned to the cancer in question. 100% relative survival signifies that deaths in the patient group were as frequent as deaths in the general population, in other words, the patients as a group may be regarded as cured from cancer.

The assumption that potential risk factors, not specifically controlled for, will be distributed similarly among patients and persons of the general population is arguably a strong one. But sensitivity analyses showed that even for lung cancer patients, who often smoke and carry a higher risk for other diseases than the general population, this did not have a concerning impact³.

¹ Dickman and Coviello 2015. Estimation and modeling relative survival. *The Stata Journal* **15**, 186-215.

² Ederer and Heise 1959. Instructions to IBM 650 programmers in processing survival computations, methodological note 10. End Results Evaluation Section, National Cancer Institute.

³ Hincliffe, Rutherford, Crowther, Nelson and Lambert 2012. Should relative survival be used with lung cancer data? *BJC* **106**, 1854-1859.

In order to compare the Swiss survival estimates between sub-groups of different age-structure within Switzerland, or with other countries, and over time, they are **age-standardized** using the method proposed by Brenner et al.⁴ and cancer-specific weights suggested as International Cancer Survival Standards (ICSS)⁵. Age-groups 15-44, 45-54, 55-64, 65-74, 75+ for each cancer type were created, and slightly adapted for prostate cancer patients, who are usually diagnosed at older ages (15-45, 55-64, 65-74, 75-84, 85+).

Assessment of vital status follow-up in Switzerland

For cantonal cancer registries to be included in the national survival statistics, the vital status of registered patients has to be systematically ascertained and **at least five years of follow-up have to be available**. These criteria included 11 of the 14 registries in existence as of 2018. Each Swiss cancer registry employs two forms of follow-up:

With passive vital status follow-up, dates of death received at regular intervals from the national or cantonal vital statistics division are linked to patient records. The quality of passive follow-up may be compromised by incomplete national or cantonal vital statistics, by false negative or false positive linkage errors, by linking only those deaths caused by cancer to patient records, by emigration of patients out of the registries catchment area or by registration of patients after the information on death was received.

With active vital status follow-up every patient registered with vital status alive is followed-up at regular intervals. This may be accomplished by repeated scrutiny of medical records in hospitals, enquiries with attending physicians, scanning the population registers, health registers of national health services, health insurance registers, electoral lists or postal/telephone enquiries. Patients for which the vital status could not be determined at the time of follow-up (e.g. because he/she has moved out of the registry population) are assigned to the category “lost to follow-up” and the last known date alive is retained.

Complete vital status follow-up is a prerequisite for valid survival statistics. Tab. 1 provides an overview of the situation of vital status follow-up information for the reference date 31.12.2015 in Switzerland. Complete information about follow-up is available for patients who have died or are alive with a recent active follow-up date (84.1% for diagnoses 1996-2000, 90.3% for diagnoses 2011-2015). The follow-up information is incomplete with lost to follow-up, or the vital status alive referring to dates in the past (i.e. before reference date), or because active follow-up is lacking, or patients were registered via death certificate only (DCO) and the data of diagnosis is unknown. The proportion of incomplete follow-up cases amounted to 15.9% for diagnoses 1996-2000, and improved to 9.7% for diagnoses 2011-2015. Patients registered as DCO or diagnosed at death were excluded from survival analysis.

⁴ Brenner H., Arndt V., Gefeller O., Hakulinen T (2004). An alternative approach to age adjustment of cancer survival rates, *European Journal of Cancer*; **40**:2317-2322.

⁵ Corraziari, Quinn and Capocaccia 2004. Standard cancer patient population for age standardizing survival ratios. *EJC* **40**, 2307-2316.

Vital-status Follow-up	Diagnoses 1996-2000 [%]	Diagnoses 2011-2015 [%]
Reference date for FU	31.12.2015	
Alive (recent active FU)	14.4	55.9
Dead	69.7	34.4
Lost to FU	2.6	0.8
Alive (past active FU)	6.8	7.2
No active FU	4.1	0.6
Dead (DCO)	2.4	1.1
Total	100.0	100.0

Tab. 1. Distribution of types of vital status and follow-up information

Assuming complete high quality passive follow-up, patients alive without active follow-up, or with active follow-up for past dates, could be treated as alive until the reference date 31.12.2015. But a survey of registration practices in Switzerland revealed that not all cancer registries linked the national or cantonal official vital statistics to registered cases for every year of incidence, or that linkage was performed only for persons with cancer as the cause of death.

We carried out a sensitivity analysis whether the assumption of continued survival in the absence of reported death could lead to implausible high estimates of survival:

Link to posters

- [“Swiss cancer survival statistics: quality of vital status follow-up \(2014\)”](#)
- [“Funnel plots to explore the quality of vital status follow-up in Switzerland \(2014\)”](#)

The assumption of continued survival in the absence of reported death caused unexpected high survival in those cancer registries with less than optimal passive follow-up procedures. Thus, the conservative approach of censoring all survival times to the last known date was adopted for national survival statistics in Switzerland.

Data selection to assess cancer survival trends

Fig. 1 shows how cancer cases were selected to assess temporal changes in cancer survival.

		Calendar year of death or last known date alive																					
		1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015		
Calendar year of diagnosis	1996	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15						
	1997		0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15					
	1998			0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15				
	1999				0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15			
	2000					0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15		
	2001																10	11	12	13	14		
	2002																9	10	11	12	13		
	2003																8	9	10	11	12		
	2004																7	8	9	10	11		
	2005																6	7	8	9	10		
	2006																5	6	7	8	9		
	2007																4	5	6	7	8		
	2008																3	4	5	6	7		
	2009																2	3	4	5	6		
	2010																1	2	3	4	5		
	2011																0	1	2	3	4		
	2012																	0	1	2	3		
	2013																		0	1	2		
	2014																			0	1		
	2015																					0	

Fig. 1. Case selection for comparing the survival of patients diagnosed 1996 to 2000 with the survival of patients diagnosed more recently and selected via follow-up dates 2011-2015.

The numbers in the cells of Fig. 1 indicate the *minimum* number of complete years of follow-up available for patients diagnosed between 1996 and 2015 (vertical axis) and who survived to the end of a given year up to 2015 (horizontal axis).

The **cohort approach** was chosen for survival of patients diagnosed 1996 to 2000 (vertical axis marked yellow in Fig. 2). Each patient diagnosed 1996-2000 has at least 15 years of follow-up by the end of 2015 (green and grey areas in Fig. 1). This approach, based on the follow-up of a clearly defined group of patients, is attractive because of its conceptual simplicity. However, the necessity to collect long-term follow-up data on every patient means that cohort survival estimates summarise more historic information on patients than what the registry currently holds.

The **period approach** always includes the most recently diagnosed patients available for each estimated survival time⁶. It estimates survival from patients selected by their time of death or last known vital status within the calendar period 2011-2015 (horizontal axis marked yellow in Fig. 1), for patients who were diagnosed during the period 1996 to 2015 (blue and grey areas in Fig. 1). Short-term survival is estimated from recently diagnosed patients (e.g. 1-year survival is estimated from patients diagnosed 2010-2014). Long-term survival is estimated from patients diagnosed earlier (e.g. 10-year survival is estimated from patients diagnosed 2001-2005). Thus, period survival includes

⁶ Brenner and Gefeller 1996. An alternative approach to monitoring cancer patient survival. *Cancer* **78**, 2004-2010

more up-to-date data than cohort analysis. However, for survival estimates in the grey area in Fig. 1, period and cohort analysis are based on the same data. Period survival analysis is conceptually more difficult to explain than cohort analysis. An alternative way to show the difference in case selection for cohort and period analysis is provided in Fig. 2. The left panel in Fig. 2 shows that in cohort analysis, short- and long-term survival probabilities are estimated from the same patient group diagnosed 1996-2000. The right panel in Fig. 2 shows that in period analysis, short term survival probabilities are estimated only from recently diagnosed patients and that patients diagnosed earlier contribute only for the estimation of long survival probabilities.

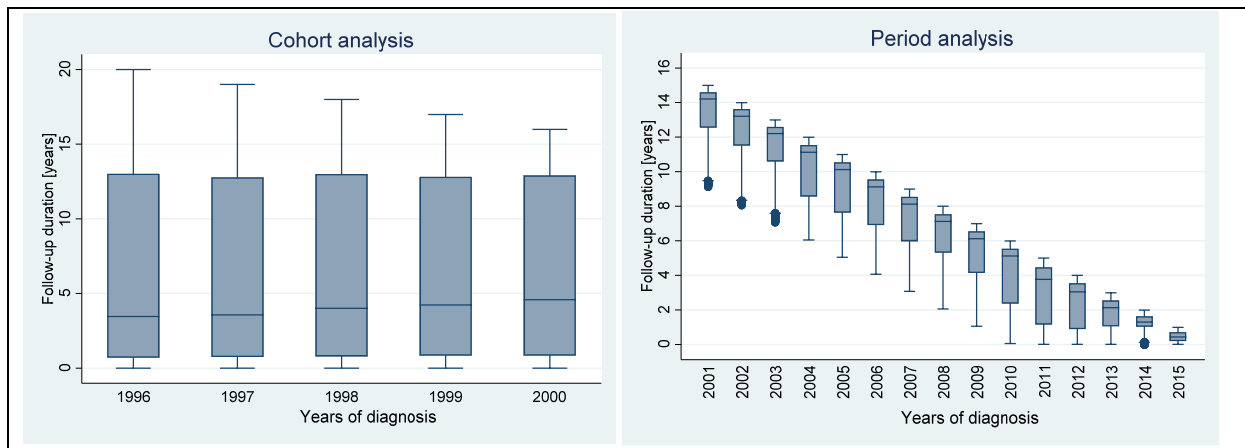


Fig. 2. Follow-up durations included for survival analysis in the cohort (left panel) and the period approach (right panel). Distribution of follow-up durations per year of diagnosis are shown as box plots, with the width of the box signifying the 25th to 75th percentile, the horizontal line the median, and the outer caps the minimum and maximum.