

An Autoantibody Test (AABT) to Aid in Early Detection of Lung Cancer in High-Risk Patients is Likely to be Cost-Effective

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BACKGROUND

- Lung cancer (LC) is most common cause of cancer death in US, in part because it typically is not diagnosed until advanced stages
- False-positives undergo additional evaluation that ultimately rules out diagnosis
- Trials suggest screening with computed tomography (CT) may yield favorable shift in LC stage at diagnosis, although a survival benefit has not been convincingly shown
- AABT—*Early*CDT-Lung (Oncimmune Ltd)—to aid in LC detection recently developed:
 - AABT comprises panel of 6 tumor-related antigens found to be present in LC several years before any tumor can be detected
- Thus, although less sensitive than CT, AABT can detect smaller, less-advanced cancers; it also has greater specificity than CT
- Patients with AABT+ (and CT+) are more likely to have LC and thus may be more aggressively evaluated and treated, which may yield tangible (eg, survival) benefits

STUDY OBJECTIVE

- To estimate cost-effectiveness of screening high-risk patients for LC with AABT, using techniques of decision-analytic modeling

STUDY METHODS

Model Description

- Model depicts clinical and economic consequences of alternative strategies for LC screening in cohort of 100,000 previously unscreened high-risk patients
- Model considers a single “prevalence-round” screening exam

Screening strategies include:

- AABT followed by CT if positive (AABT→CT)
- AABT plus CT (AABT+CT)
- CT alone
- No Screening

- Patients assumed to be 60 years of age and at high-risk of having previously undetected LC due to current or former smoking:

- NSCLC—aggressive and indolent types—and SCLC considered

- Patients classified into one of four groups—true-positive, true-negative, false-positive, false-negative—based on LC+ vs LC- and screening+ vs screening-

- True-positives undergo further diagnostic evaluation followed by LC treatment:

- Diagnostic tests employed, and their scheduling, depend on whether AABT and/or CT are positive, and nodule size

- Detection of aggressive NSCLC/SCLC by CT screening yields earlier stage and smaller tumor (NSCLC stage 1), which confer survival benefits (vs no screening):

- LC detected with AABT assumed, on average, to be smaller and less advanced, which results in stage, size, and survival benefits

- Detection of indolent NSCLC by screening (“overdiagnosis bias”) generates additional costs but confers no survival benefit

Model Description (Cont.)

- True-negatives undergo no further diagnostic evaluation
- False-positives undergo additional evaluation that ultimately rules out diagnosis
- False-negatives with aggressive NSCLC/SCLC are correctly diagnosed, on average, 12 months following screening and subsequently undergo LC treatment:
 - Cancer assumed to have same size/stage as that detected in clinical practice, and thus to be more advanced than that for true-positives
 - Most patients with false-negative indolent NSCLC are never diagnosed
- Costs include: initial screening (all patients); follow-up diagnostic evaluation (true-positives and false-positives); LC treatment (true-positives and false-negatives)
- Study perspective: healthcare system
- Future benefits and costs (2008US\$) discounted at 3% per year

Model Estimation

- LC prevalence estimated assuming a three-year “look-forward period”:
 - AABT+ could result from tumor detectable by CT at time of screening or from one so small it would not be detectable by CT for up to three years
- CT sensitivity/specificity calculated from “prevalence-screen” perspective based on results of Mayo Clinic study^{1,2}; for AABT, estimates based on published data^{4,5}

Table 1. Estimated values of selected model parameters

Model Parameter	Value		Reference
	NSCLC	SCLC	
Disease Characteristics			
Prevalence of Lung Cancer, %	3.20%	0.56%	1-3, 6, 7
Type of Lung Cancer, %	85%	15%	7
Screening Test Characteristics			
CT			1-3
Sensitivity	47%	47%	
Specificity	49%	49%	
AABT			4, 5
Sensitivity	40%	40%	
Specificity	90%	90%	
Stage Shift vs No Screening, %			
CT	50%	25%	8 (NSCLC), Expert Opinion (SCLC)
AABT→CT	80%	40%	Expert Opinion
AABT+CT	67.6%	34.3%	Derived
Size Shift (Stage 1) vs No Screening, mm			
CT	16.0	---	2
AABT→CT	18.0	---	Expert Opinion
AABT+CT	17.2	---	Derived
Overdiagnosis Bias, %	27%	---	9
Costs			
Initial Screen			
CT	\$301	\$301	10
AABT	\$300	\$300	Assumed
LC Treatment			
Initial Year (Stage 1 - 4)	\$35,871 - \$50,346	\$50,346	
Continuing Years (Annual)	\$4,576	\$4,576	
Last Year of Life (Stage 1 - 4)	\$46,295 - \$78,623	\$78,623	

Analyses

- Cost-effectiveness calculated as ratio of difference in expected costs to difference in expected quality-adjusted life-years (QALYs) between:
 - AABT→CT vs No Screening and CT alone, respectively
 - AABT+CT vs No Screening and CT alone, respectively
 - CT vs No Screening

RESULTS

Outcomes

- Of 2,901 cases of aggressive NSCLC/SCLC, 1,161 (true-positives) would be detected with AABT→CT, 1,979 with AABT+CT, and 1,363 with CT alone; false-positives would total 9,623 (AABT→CT), 53,794 (AABT+CT), and 49,079 (CT alone)

Table 2. Classification from screening for lung cancer in a hypothetical population of 100,000 current/former smokers

	No Screening	CT	AABT→CT	AABT+CT
True Negatives	96,234	47,155	86,611	42,440
False Positives	---	49,079	9,623	53,794
True Positives	---	1,770	1,507	2,569
NSCLC	---	1,505	1,281	2,184
Aggressive	---	1,098	935	1,594
Indolent	---	407	346	590
SCLC	---	265	226	385
False Negatives	3,766	1,996	2,259	1,197
NSCLC	3,202	1,697	1,921	1,018
Aggressive	2,337	1,239	1,402	743
Indolent	865	458	519	275
Detected	123	0	0	0
Undetected	742	458	519	275
SCLC	564	299	338	179

- Compared with no screening, screening would increase costs by \$497 (AABT→CT), \$1242 (AABT+CT), and \$802 (CT alone) per patient, and yield an additional 0.04 (AABT→CT), 0.05 (AABT+CT), and 0.03 (CT alone) QALYs per patient

Table 3. Outcomes from screening for lung cancer in a hypothetical population of 100,000 current/former smokers*

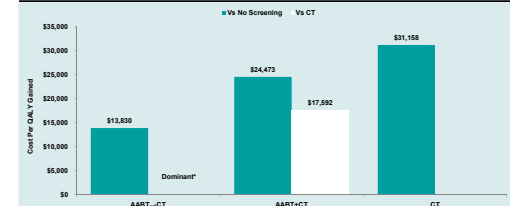
	No Screening	CT	AABT→CT	AABT+CT
Life-Years	1,506	1,510	1,511	1,513
Quality-Adjusted Life-Years	1,303	1,306	1,307	1,308
Cost	\$230,947	\$311,162	\$280,676	\$355,165
Screening	\$0	\$30,051	\$33,345	\$60,051
Diagnostic Follow-up	\$10,481	\$51,227	\$23,018	\$61,011
Treatment	\$220,466	\$229,883	\$224,313	\$234,103

*Discounted values, in 000s

RESULTS (Cont.)

Cost-Effectiveness

Figure. Cost-effectiveness of screening for lung cancer with AABT→CT and AABT+CT versus no screening and versus screening with CT alone, respectively



*Less costly, more effective

Sensitivity Analyses

Table 4. Sensitivity analyses on cost per QALY gained

Base Case	AABT→CT vs		AABT+CT vs	
	No Screen	CT	No Screen	CT
Prevalence	\$13,830	Dominant	\$24,473	\$17,592
Age 50 (1.07%)	\$22,329	Dominant	\$55,775	\$39,848
Age 70 (1.88%)	\$13,902	Dominant	\$22,004	\$17,359
Cost of AABT screening				
\$0	\$5,487	Dominant	\$18,563	\$5,598
\$100	\$8,268	Dominant	\$20,533	\$9,596
\$200	\$10,949	Dominant	\$22,001	\$13,994
\$500	\$19,392	Dominant	\$28,413	\$25,588
Sensitivity - AABT				
20%	\$24,413	\$48,272 (CT)	\$28,331	\$24,069
30%	\$17,432	Dominant	\$26,230	\$20,203
80%	\$10,182	Dominant	\$21,085	\$14,271
90%	\$18,722	Dominant	\$26,496	\$21,697
95%	\$13,284	Dominant	\$23,662	\$15,646
Stage Shift - AABT→CT				
NSCLC 65% vs 50%, SCLC 40% vs 25%	---	Dominant	---	---
NSCLC 50% vs 35%, SCLC 40% vs 25%	---	Dominant	---	---
NSCLC 25% vs 10%, SCLC 40% vs 25%	---	Dominant	---	---
NSCLC 80% vs 60%, SCLC 0% vs 0%	---	Dominant	---	---
Stage Shift - AABT+CT vs CT				
NSCLC 65% vs 50%, SCLC 40% vs 25%	---	Dominant	---	---
NSCLC 50% vs 35%, SCLC 40% vs 25%	---	Dominant	---	---
NSCLC 25% vs 10%, SCLC 40% vs 25%	---	Dominant	---	---
NSCLC 80% vs 60%, SCLC 0% vs 0%	---	Dominant	---	---
Stage Shift - AABT→CT vs CT				
NSCLC 50% vs 35%, SCLC 34.3% vs 25%	---	---	---	\$46,119
NSCLC 25% vs 10%, SCLC 34.3% vs 25%	---	---	---	\$78,472

CONCLUSION AND CLINICAL IMPLICATION

- Screening high-risk patients for LC using AABT, in conjunction with CT, is likely to be cost-effective by current standards in comparison with CT screening or no screening
- Use of AABT in early detection of lung cancer is supported by clinical as well as economic evidence

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