Angie, Andy, Susan, John, Nick, Jenica, Matt

5/9/23

**Qs about histology – “other”**

* For RAPID, AMR to send Nick the patient IDS for the “other”. Otherwise, okay to count with other and impute
  + For RAPID, they did not do central review, but the UK does review locally for hematology diagnoses
* For NCIC, Annette leans towards calling NOS (but doesn’t feel strongly) after speaking to hematopathology colleagues about the two interfollicular cases from HD.6
* For H10, “other” and “unclassified” categories
  + 11 initially categorized as other but they have no additional info
    - Decision to exclude
  + 41 initially categorized as unclassified and AMR has been counting as NOS
    - Decision to include as CHL NOS
    - Follow up with study team (John, Marc, Martin) and CC John, Andy, SKP
* Send an email to EORTC saying this is what we are going to do unless we hear from you (John Raemaekers 🡪 Martin Hutchings, Marc Andre)

**Update on data decisions**

* Decision to exclude 3 Waldeyer’s only cases
* Inclusion/exclusion: age 18-65; cHL; early stage disease; no above & below diaphragm disease (confirm that these didn’t retrocrural by looking at free text & AMR to pull out and send to Andy); no count of 0 EORTC nodal groups
  + Registries further restricted to: treated with curative intent; not treated on a trial; diagnosed 1996 to 2019
  + Exclude patients that are missing more than half of the candidate variables
* Candidate variables:
  + Age, sex, stage, B symptoms, measure of mediastinal bulk, 5 histology groups, 5 lab values, cervical nodal group, infraclavicular nodal group, mediastinal group
* Outcome:
  + Focus on PFS
  + Will not build OS model because of small number of events
    - Will still report TY OS
  + Who to do with 8 that are missing outcomes from H10?
    - Decision to “censor at 1 day” (Matt)
* Q: median follow time of trials and registries?
  + Median follow up time in trials=60 months; follow time in registry=74 months

**Bulk**

* Most interested in mediastinal region
* Most cases are binary for variable type
  + Continuous might just be size of tumor vs. ratio
* Able to define yes/no mediastinal bulk for all trials
* Missing continuous measures for NCIC
* H10 is more complete as ratio than bulk in cm
* RAPID is missing mediastinal bulk as ratio
* Q: optimal cut point for continuous cm?
  + 5 cm in RAPID initially, validated on H10
  + Can look at mediastinal bulk also as above or below 5
* No continuous data from the registries currently; will need to be extracted
  + PMH has 1 measure: maximum, so don’t know if it is mediastinal or not but generally bulk above diaphragm would be mediastinal
  + Decision to use largest measure of continuous bulk (MTD = maximum tumor diameter at baseline)
* For Australia missingness/inconsistently described: Could restrict imputation to sizes between 0 and 5 cm.
* AMR to double check n=31 missing bulk & follow-up with Nick