

# A combination of routine laboratory findings and vital signs can predict survival of advanced cancer patients without physician evaluation: a fractional polynomial model

|                              |  |
|------------------------------|--|
| 著者 (英)                       | Jun HAMANO, Ayano Takeuchi, Takuhiro Yamaguchi, Mika Baba, Kengo Imai, Masayuki Ikenaga, Yoshihisa Matsumoto, Ryuichi Sekine, Takashi Yamaguchi, Takeshi Hirohashi, Tsukasa Tajima, Ryohei Tatara, Hiroaki Watanabe, Hiroyuki Otani, Hiroka NAGAOKA, Masanori Mori, Yo Tei, Shuji Hiramoto, Tatsuya Morita |
| journal or publication title | European Journal of Cancer   |
| volume                       | 105  |
| page range                   | 50-60  |
| year                         | 2018-12  |
| 権利                           | (C) <2018>. This manuscript version is made available under the CC-BY-NC-ND 4.0 license <a href="http://creativecommons.org/licenses/by-nc-nd/4.0/">http://creativecommons.org/licenses/by-nc-nd/4.0/</a>  |
| URL                          | <a href="http://hdl.handle.net/2241/00154189">http://hdl.handle.net/2241/00154189</a>  |

A combination of routine laboratory findings and vital signs can predict survival of advanced cancer patients without physician evaluation: a fractional polynomial model

**Authors' full names, degrees, affiliations, and addresses:**

Jun Hamano, M.D.

junhamano@md.tsukuba.ac.jp

Division of Clinical Medicine, Faculty of Medicine, University of Tsukuba

1-1-1 Tennoudai, Tsukuba, Ibaraki 305-8575, Japan

Ayano Takeuchi

ayanotakeuchi@keio.jp

Department of Preventive Medicine and Public Health, School of Medicine, Keio University

35 Shinanomachi, Shinjyuku-ku, Tokyo 160-8582, Japan

Takuhiro Yamaguchi

yamaguchi@med.tohoku.ac.jp

Division of Biostatistics, Tohoku University Graduate School of Medicine,

1-1, Seiryomachi, Aoba-ku, Sendai, Miyagi 980-8574, Japan

Mika Baba, M.D.

mmika@s9.dion.ne.jp

Department of Palliative Medicine, Suita Tokushukai Hospital

21-1 Senriokanishi, Suita, Osaka 565-0814, Japan

Kengo Imai, M.D.

k.imai@sis.seirei.or.jp

Seirei Hospice, Seirei Mikatahara General Hospital

3453 Mikatahara-cho, Kita-ku, Hamamatsu, Shizuoka 433-8558, Japan

Masayuki Ikenaga, M.D.

a190185@ych.or.jp

Hospice Children's Hospice Hospital, Yodogawa Christian Hospital

6-9-3, Higashinakagima, Higashiyodogawa-ku, Osaka city, 533-0033, Japan

Yoshihisa Matsumoto, M.D.

yosmatsu@east.ncc.go.jp

Department of Palliative Medicine, National Cancer Center Hospital East  
6-5-1, Kashiwanoha, Kashiwa, Chiba 277-8577, Japan

Ryuichi Sekine, M.D.

sekiner@kameda.jp

Department of Pain and Palliative Care, Kameda Medical Center  
Higashi-Cho 929, Kamogawa City, Chiba, 296-8602, Japan

Takashi Yamaguchi, M.D.

ikagoro@pop06.odn.ne.jp

Department of Palliative Medicine  
Kobe University Graduate School of Medicine  
7-5-1, Kusunokicho, Chuo-ku, Kobe, Hyogo, 650-0017, Japan

Takeshi Hirohashi, M.D.

hirohashi.med@gmail.com

Department of Palliative Care, Mitsui Memorial Hospital  
1 Kandaizumicho, Chiyoda-ku, Tokyo, 101-8643, Japan

Tsukasa Tajima, M.D.

ttajima@med.tohoku.ac.jp

Department of Palliative Medicine, Tohoku University Hospital  
1-1 Seiryomachi, Aobaku, Sendai, 980-8574, Japan

Ryohei Tatara, M.D.

r-tatara@hotmail.co.jp

Osaka City General Hospital, Department of Palliative Medicine  
2-13-22 Miyakojima-hondori Miyakojima-ku Osaka, 534-0021, Japan

Hiroaki Watanabe, M.D.

hi.watanabe@komakihp.gr.jp

Komaki City Hospital  
1-20 Jobushi, Komaki-city, Aichi, 485-8520, Japan

Hiroyuki Otani, M.D.

cas60020@pop21.odn.ne.jp

Department of Palliative Care Team, and Palliative and Supportive Care, National  
Kyushu Cancer Center

3-1-1 Notame, Minami-ku, Fukuoka, 811-1395, Japan

Hiroka Nagaoka, M.D.

nagaoka3taro@gmail.com

Division of Clinical Medicine, Faculty of Medicine, University of Tsukuba

1-1-1 Tennoudai, Tsukuba, Ibaraki 305-8575, Japan

Masanori Mori, M.D.

Masanori.Mori@sis.seirei.or.jp

Seirei Hamamatsu General Hospital

2-12-12, Sumiyoshi, Naka-ku, Hamamatsu, Shizuoka, 430-8558, Japan

Yo Tei, M.D.

y-jeong680909@ktb.biglobe.ne.jp

Seirei Hospice, Seirei Mikatahara General Hospital

3453 Mikatahara-cho, Kita-ku, Hamamatsu city, Shizuoka, 433-8558, Japan

Shuji Hiramoto, M.D.

otomari1rx.8@gmail.com

Department of Oncology, Mitsubishi Kyoto Hospital

Goshochō 1 Katsura Nishikyoku Kyoto, 615-8087, Japan

Tatsuya Morita, M.D.

tmorita@sis.seirei.or.jp

Department of Palliative and Supportive Care, Palliative Care Team, and Seirei Hospice,  
Seirei Mikatahara General Hospital

3453 Mikatahara-cho, Kita-ku, Hamamatsu, Shizuoka 433-8558, Japan

**Corresponding author**

Jun Hamano, M.D., Ph.D.

Division of Clinical Medicine, Faculty of Medicine, University of Tsukuba

1-1-1 Tennoudai, Tsukuba, Ibaraki 305-8575, Japan

Tel: +81-298-53-3189, Fax: +81-298-53-3189

E-mail: junhamano@md.tsukuba.ac.jp

**Running head:** Objective survival prediction for advanced cancer patients

**Role of the Funding Source**

This study was funded by the National Cancer Center Research and Development Fund (25-A-22). The sponsor played no role in study design; collection, analysis, and interpretation of the data; writing of the report and the decision to submit the paper for publication.

**Declaration of interests :** None of the authors has financial and personal relationships to declare.

Abstract words; 245

Text words; 2499

Tables; 3 (Appendix; 1)

Figures; 3

References 30

## **Abstract**

**Introduction:** There have been no reports about predicting survival of patients with advanced cancer constructed entirely with objective variables. We aimed to develop a prognostic model based on laboratory findings and vital signs using a fractional polynomials (FP) model.

**Methods:** A multicenter prospective cohort study was conducted at 58 specialist palliative care services in Japan from September 2012 to April 2014. Eligible patients were > 20 years old and had advanced cancer. We developed models for predicting 7-day, 14-day, 30-day, 56-day, and 90-day survival by using the FP modelling method.

**Results:** Data from 1039 patients were analyzed to develop each prognostic model (Objective Prognostic Index for advanced cancer: OPI-AC). All models included the heart rate, urea, and albumin, while some models included the respiratory rate, creatinine, C-reactive protein, lymphocyte count, neutrophil count, total bilirubin, lactate dehydrogenase, and platelet / lymphocyte ratio. The area under the curve was 0.77, 0.81, 0.90, 0.90, and 0.92 for the 7-day, 14-day, 30-day, 56-day, and 90-day model, respectively. The accuracy of the OPI-AC predicting 30-day, 56-day, and 90-day survival was significantly higher than that of the Palliative Prognostic Score or the Prognosis in Palliative Care Study model, which are based on a combination of symptoms and physician estimation.

**Conclusion:** We developed highly accurate prognostic indexes for predicting the survival of patients with advanced cancer from objective variables alone, which may be useful for end-of-life management. The FP modelling method could be promising for developing other prognostic models in future research.

**Keywords:** prognostic index, laboratory findings, vital signs, fractional polynomials model

## **Introduction**

For patients with life-threatening illnesses such as advanced cancer, accurate prognostic information is essential to provide the opportunity for patients, family members, and clinicians to engage in open discussion about advance care planning[1–3].

Several validated prognostic tools have been developed to predict the survival of patients with advanced cancer[4], including the Palliative Prognostic Index (PPI)[5], Palliative Prognostic Score (PaP score)[6], and Prognosis in Palliative Care Study (PiPS)[7]. These have acceptable predictive accuracy with area under the curve (AUC) values of 0.62-0.86[7,8], but a major limitation is use of subjective variables, such as the patient's symptoms and condition (e.g., performance status) and the physician's prediction of survival[9–11]. Recent studies have revealed that such subjective variables are influenced by the evaluator's experience and competence[11,12]. Therefore, more extensive use of objective variables, such as laboratory findings and vital signs, has been strongly recommended when developing prognostic models[13–17].

Furthermore, the existing prediction tools are based on routine statistical methods such as regression analysis, but the guidelines for transparent reporting of a multivariable model for individual prognosis or diagnosis (TRIPOD statement) recommend the fractional polynomials (FP) modelling method as one of the ideal approaches for



developing a multivariable prediction model[18].

To our best knowledge, there are currently only 2 prognostic models that are entirely composed of objective variables, which are the Objective Palliative Prognostic Score (OPPS) and the set of six adaptable prognosis prediction (SAP) models[19,20]. The OPPS predicts 7-day survival by using 6 variables (heart rate, white blood cell count, platelet count, creatinine, potassium, and history of chemotherapy) and has an AUC of 0.82[19]. The SAP models predict survival for 1–6 months by using 3 variables (neutrophil count, lactate dehydrogenase, and albumin), with AUC values ranging from 0.71 to 0.85[20]. Although these models suggest that exclusive use of objective parameters may allow successful prediction of survival, several major limitations should be noted: development from a small patient sample, no validation study, limited or varied target time span, and lack of advanced statistical methods.

Therefore, we decided to explore the accuracy of a prognostic index that only incorporated objective parameters (laboratory findings and vital signs) and was based on the FP modelling method. We wanted to obtain insights into the predictability of patient survival using only objective parameters and the variables that would be effective for prediction of short-term to long-term survival. Accordingly, this study was performed to develop prognostic models for prediction of short-term to long-term survival

using only objective parameters and the FP modelling method.

## **Material and Methods**

This study was a secondary analysis of the Japan-prognostic assessment tools validation (J-ProVal) study, which was a multicentre prospective cohort study performed to investigate the feasibility and accuracy of existing prognostic tools[21]. It was conducted at 58 palliative care services in Japan from September 2012 through April 2014. The participating services included 19 hospital palliative care teams, 16 palliative care units, and 23 home-based palliative care services. The primary physician of each patient performed evaluation and recorded demographic and clinical characteristics of the participants. Data from laboratory tests were only obtained if the patient underwent blood tests as a clinical necessity within 1 week after enrolment.

This study was conducted in accordance with the ethical standards of the Helsinki Declaration and the ethical guidelines for epidemiological research presented by the Ministry of Health, Labour and Welfare of Japan. The Institutional Review Boards of all participating services approved this study.

### **Patients**

Eligible patients were enrolled consecutively as they were referred to the participating

services during the study period. All services were asked to evaluate and collect data on a specific number of patients, ranging from 20 to 100, based on the size of the service. Patients were eligible for the study if they were adults (aged 20 years or older) with locally advanced or metastatic cancer (including hematopoietic neoplasms) who had been admitted to a palliative care unit, referred to a hospital palliative care team, or were receiving home-based palliative care.

#### Outcome

We used the FP method to develop prognostic models based on laboratory findings and vital signs for predicting the 7-day, 14-day, 30-day, 56-day, and 90-day survival of patients with advanced cancer (Objective Prognostic Index for advanced cancer: OPI-AC).

#### Measurements and Variables

The physician assessed variables on the day of admission, including the patient's age, gender, site of the primary tumor and metastases, anticancer treatment during the 1-month period before assessment (i.e., chemotherapy, hormone therapy, or radiotherapy), symptoms and general condition, vital signs (heart rate and respiratory rate), and the results of blood tests performed during the 1-week period before assessment. The

following laboratory tests were assessed: leukocyte count ( $10^9/L$ ), neutrophil count ( $10^9/L$ ), lymphocyte count ( $10^9/L$ ), platelet count ( $10^9/L$ ), urea (mg/dL), creatinine (mg/dL), alanine transaminase (U/L), alkaline phosphatase (U/L), total bilirubin (mg/dL), lactate dehydrogenase (U/L), albumin (g/dL), and C reactive protein (mg/dL). Physicians followed the patients until death or 6 months after enrolment.

We used the heart rate and respiratory rate on the day of admission and the laboratory data obtained during the 1-week period before assessment as objective variables. We also added 3 composite variables, which were the neutrophil / lymphocyte ratio (NLR)[22], Prognostic Nutritional Index (PNI)[23], and platelet / lymphocyte ratio (PLR)[24]. Thus, a total of 17 variables were considered for the prognostic models.

#### Modified PiPS-B14/56

The modified PiPS-B14/56 can identify patients with an expected survival of days (0-13 days) or weeks (14-55 days), respectively. Scores were calculated from the following variables: symptoms (presence or absence of anorexia, dyspnoea, dysphagia, fatigue, and weight loss during the last month); Eastern Cooperative Oncology Group performance status; global health status (1 = extremely poor health, 7 = normal health); cognitive status assessed according to the Abbreviated Mental Test score; pulse rate; and

laboratory data (leukocyte count, neutrophil count, lymphocyte count, platelet count, urea, creatinine, alanine aminotransferase, alkaline phosphatase, total bilirubin, lactate dehydrogenase, albumin, and C-reactive protein). Cognitive status was evaluated according to the Abbreviated Mental Test score by physician proxy, and was rated as zero if the score was  $\leq 3$  points[7,21].

#### PaP score

PaP scores were used to classify patients into three groups according to the probability of 30-day survival: group A  $>70\%$ , group B  $30\text{--}70\%$ , and group C  $<30\%$ [6]. PaP scores were calculated from the following variables: symptoms (presence or absent of dyspnoea and anorexia); Karnofsky Performance Status; clinical prediction of survival ( $>12$ ,  $11\text{--}12$ ,  $7\text{--}10$ ,  $5\text{--}6$ ,  $3\text{--}4$ , and  $1\text{--}2$  weeks); and laboratory findings (leucocyte count and lymphocyte percentage)[6].

#### SAP models

SAP models are used to predict death within 1–6 months for cancer patients on chemotherapy[20]. Scores were calculated from data on the neutrophil count, lactate dehydrogenase, and albumin. The regression equation corresponding to each prediction

period was  $p=1/(1+\exp(-C_{Alb}\times Alb - C_{Alb} - C_{LDH}\times LDH - C_{Neutrophil}\times Neutrophil - \text{const.}))$

## Statistical analysis

Comparison of patient background factors was performed by using the Student t-test, chi-square test, or log-rank test, as appropriate. We used the FP modelling method to predict the survival time (in days) from enrolment to death. FP modelling is an alternative to standard polynomial regression models and provides more flexible parameterization based on fractional polynomial functions[25]. All 17 variables were entered into the initial FP model: heart rate, respiratory rate, leukocyte count, neutrophil count, lymphocyte count, platelet count, urea, creatinine, alanine aminotransferase, alkaline phosphatase, total bilirubin, lactate dehydrogenase, albumin, C-reactive protein, NLR, PNI, and PLR. Then, we conducted 10-fold cross validation to correct for over-optimism in development of the models and identified the model with the best predictive accuracy for each target survival period.

FP modelling differs from regular polynomials in that logarithms and noninteger powers can be employed, and powers can also be repeated. We used the degree-2 fractional polynomial of  $x$  for regression. The FP modelling technique employed the equation  $Y=\beta_0+\beta_1X^{(p1)}+\beta_2X^{(p2)}$ , where  $p1$ , and  $p2$  are exponent powers selected from among  $\{-2, -1,$

-0.5, 0, 0.5, 1, 2, and 3}, with the model showing the best fit being chosen. The convention is that  $X_0$  equals  $\text{LN}(X)$ [26,27].

We also estimated the probability of survival using various prognostic models, i.e., the FP, PiPS-B 14/56, PaP, and SAP models, by calculating the AUC values. Using three patients extracted from the database, the survival times targeted by each model at the time of development were compared, i.e., 14-day survival for the PiPS-B 14 model, 30-day survival for the PaP model, 30/56/90-day survival for the SAP models, and 56-day survival for the PiPS-B 56 model. All analyses were carried out using SAS software (ver. 9.4) and R software (ver. 3.4.4), and  $p < 0.05$  was considered significant.

## **Results**

### **Participants**

A total of 2426 subjects were recruited in the original study. Among them, 1387 patients were excluded because of missing data (date of death, laboratory findings, or vital signs), and we analyzed the remaining 1039 patients for this study. Patient characteristics are summarized in Table 1. The mean age of the patients was 67.7 years, and lung cancer was the most frequent primary cancer, followed by cancer of the stomach/esophagus. The median survival time was 33 days. Among the patients analyzed, 24.9% and 5.6% were



receiving chemotherapy and/or radiotherapy, respectively. Patient background factors including survival periods were largely consistent between the analyzed and non-analyzed patients (Appendix 1), except that the analyzed patients were significantly younger, showed male predominance, had more metastatic tumors, and more chemotherapy. Laboratory findings are summarized in Table 2.

#### FP models and performance

Table 3 summarizes the best FP models for predicting 7-day, 14-day, 30-day, 56-day, and 90-day survival. We designated each of these models as an OPI-AC. All indexes included heart rate, urea, and albumin. In addition, the respiratory rate, creatinine, C-reactive protein, lymphocyte count, neutrophil count, total bilirubin, lactate dehydrogenase, and PLR were included in some indexes. The AUC values of these OPI-AC models exceeded 0.89 for prediction of 30-day to 90-day survival, while the AUC was 0.77 for 7-day survival and 0.81 for 14-day survival (Table 3). Accuracy of the OPI-AC was better than the PiPS-B 56 model (0.89 vs. 0.83), the PaP model (0.89 vs. 0.87), and all three SAP models (0.89-0.92 vs. 0.74-0.82).

Examples of using OPI-AC (Figure 1,2,3)

We calculated the estimated probability of survival for three patients using all of the OPI-AC models. Patient A died 10 days after enrolment, and the largest change in the estimated probability of survival was noted between 7 and 14 days (Figure 1). Similarly, the largest change was seen between 14 and 30 days for patient B who died 27 days after enrolment (Figure 2). Patient C died 53 days after enrolment, and the second largest change in the estimated probability of survival was noted between 30 and 56 days for this patient (Figure 3).

## Discussion

Prediction of patient survival with minimum bias is challenging. In this study, we demonstrated that the prognostic prediction model using only objective data (i.e., routine laboratory findings and vital signs) showed high accuracy than existing prediction tools requiring direct patient assessment by physicians and health care professionals.

The most important finding of this study was that the OPI-AC models for relatively longer survival (30-90 days) were more accurate than existing predictive models that include subjective patient factors and physician evaluation. That is, the AUC for the 30-day OPI-AC was 0.89, while the AUC for the PaP score was 0.87 in this dataset and 0.72 in the original study[8]. Similarly, the AUC for the 56-day OPI-AC was 0.90, while the AUC for the PiPS-B 56 model was 0.83 in this dataset and 0.81 in the original study[7]. These findings indicate that prediction of survival by FP modelling is sufficiently accurate, even when based entirely on objective variables (i.e., laboratory findings and vital signs) without data from direct examination of the patient by a physician or other healthcare professional.

Furthermore, the AUC for the 90-day OPI-AC was larger than that for the SAP model, a linear model incorporating 3 laboratory parameters that was developed from a large

prospective cohort database accumulated at a single centre[20]. AUC values for the 30-day, 56-day, and 90-day OPI-AC were 0.89, 0.90, and 0.92, respectively. In contrast, the AUC values for the 1-month, 2-month, and 3-month SAP models were respectively 0.74, 0.77, and 0.82 in the present study, or 0.74, 0.70, and 0.71 in the original reports[20]. These results indicate that addition of more variables and use of converted variables can contribute to improvement of predictive accuracy.

However, the OPI-AC showed relatively lower accuracy for predicting short-term survival, with the AUC values of the 7-day and 14-day OPI-AC being were 0.77 and 0.81 respectively. Among the other models, the AUC for prediction of 7-day survival using the OPPS was 0.82 (0.75-0.89) in a Korean study[19], while the AUC for prediction of 14-day survival using the PiPS-B14 was 0.86 (0.84-0.89)[7]. One possible reason is that the 7-day and 14-day OPI-AC did not include sodium, which might be sensitive marker of impending death,[13] so addition of sodium could contribute to improving the predictive power[13]. Another possible reason is that relatively small number of patients who died in period of 7-days, 14-days might lead to instability of constructed prediction models. A more likely interpretation is that prediction of impending death is improved by assessing changes of vital signs and physical findings, such as drooping of the nasolabial fold, respiration with mandibular movement, or the death rattle[15–17]. These findings

suggest that further investigation of indexes containing more variables or daily changes of variables is required to determine whether relatively short-term survival can be predicted from objective data alone.

Regarding clinical practice, the OPI-AC makes it possible to predict the survival of patients without direct involvement of physicians or other healthcare professionals. As previous studies have shown that physicians tend to markedly overestimate the survival of patients,[9,28] our models could be useful to improve the conversation among patients, families, and physicians regarding preparation for end-of-life care [29,30].

In terms of research implications, FP modelling seems to be a strong method for developing prognostic models. We stress the importance of the methodology itself rather than the details of the formula, as the formula may change when using more data or a different study population, but the basic methodology is widely applicable[26,27]. In addition, our prognostic model could be used to identify patients who are eligible for participation in clinical trials to minimize attrition rates.

This study has some limitations. First, the subjects analyzed in this study were limited to patients who received blood test due to clinical necessity. There may be a selective bias, but the patient backgrounds were similar between analyzed and non-analyzed patients and we believe this bias would not have large influence on the results. Second, although

we conducted 10-fold cross validation in this study, no external validation was performed.

Independent validation might add some insights for final model.

## **Conclusions**

We used FP modelling to develop highly accurate prognostic models for patients with advanced cancer that exclusively employed objective variables (OPI-AC). Accurate objective prediction may facilitate conversations about end-of-life care, and FP modelling seems to be a promising method for development of other prognostic indexes in future research.

## **Acknowledgements**

This work was supported in part by The National Cancer Center Research and Development Fund (25-A-22). This study was performed by the Japan ProVal Study Group (Prognostic scores Validation Study Group). The participating study sites and investigators were: Satoshi Inoue, M.D. (Seirei Hospice, Seirei Mikatahara General Hospital), Masayuki Ikenaga, M.D. (Hospice Children's Hospice Hospital, Yodogawa Christian Hospital), Yoshihisa Matsumoto, M.D., Ph.D. (Department of Palliative Medicine, National Cancer Center Hospital East), Mika Baba, M.D. (Saito Yukoukai Hospital Department of Palliative Care), Ryuichi Sekine, M.D. (Department of Pain and Palliative Care, Kameda Medical Center), Takashi Yamaguchi, M.D., Ph.D. (Department of Palliative Medicine, Kobe University Graduate School of Medicine), Takeshi Hirohashi, M.D. (Department of Palliative Care, Mitui Memorial Hospital), Tsukasa Tajima, M.D. (Department of Palliative Medicine, Tohoku University Hospital), Ryohei Tatara, M.D. (Osaka City General Hospital, Department of Palliative Medicine), Hiroaki Watanabe, M.D. (Komaki City Hospital), Hiroyuki Otani, M.D. (Department of

Palliative Care Team, and Palliative and Supportive Care, National Kyushu Cancer Center), Chizuko Takigawa, M.D. (Department of Palliative Care, KKR Sapporo Medical Center), Yoshinobu Matsuda, M.D. (Department of Psychosomatic Medicine, National Hospital), Hiroka Nagaoka, M.D. (University of Tsukuba, Department of Medical Social Service Center for Palliative), Masanori Mori, M.D. (Seirei Hamamatsu General Hospital), Yo Tei, M.D. (Seirei Hospice, Seirei Mikatahara General Hospital), Shuji Hiramoto, M.D. (Department of Oncology, Mitsubishi Kyoto Hospital), Akihiko Suga, M.D. (Department of Palliative Medicine Shizuoka Saiseikai General Hospital), Takayuki Hisanaga, M.D. (Tsukuba Medical Center Foundation), Tatsuhiko Ishihara, M.D. (Okayama Saiseikai General Hospital, Palliative Care Department), Tomoyuki Iwashita, M.D. (Matsue City Hospital), Keisuke Kaneishi, M.D., Ph.D. (Department of Palliative Care Unit, JCHO Tokyo Shinjuku Medical Center), Shohei Kawagoe, M.D. (Aozora Clinic), Toshiyuki Kuriyama, M.D., Ph.D. (Wakayama Medical University Hospital Oncology Center, Department of Palliative Medicine), Takashi Maeda, M.D. (Department of Palliative Care, Tokyo Metropolitan Cancer and Infectious Disease Center Komagome Hospital), Ichiro Mori, M.D. (Gratia Hospital Hospice), Nobuhisa Nakajima, M.D., Ph.D. (Department of Palliative Medicine, Graduate School of Medicine, Tohoku University), Tomohiro Nishi, M.D. (Kawasaki Comprehensive Care Center, Kawasaki Municipal Ida Hospital), Hiroki Sakurai, M.D. (Department of Palliative Care, St. Luke's International Hospital, Tokyo), Satofumi Shimoyama, M.D., Ph.D. (Department of Palliative Care, Aichi Cancer Center Hospital), Takuya Shinjo, M.D. (Shinjo Clinic, Kobe), Hiroto Shirayama, M.D. (Iryouhoujinn Takumikai Osaka Kita Homecare Clinic), Takeshi Yamada, M.D., Ph.D. (Department of Gastrointestinal and Hepato-Biliary-Pancreatic Surgery, Nippon Medical School), Shigeki Ono, M.D. (Division of Palliative Medicine, Shizuoka Cancer Center Hospital), Taketoshi Ozawa, M.D., Ph.D. (Megumi Zaitaku Clinic), Ryo Yamamoto, M.D. (Saku Central Hospital Advanced Care Center, Department of Palliative Medicine), Naoki Yamamoto, M.D., Ph.D. (Shinsei Hospital, Department of Primary Care Service), Hideki Shishido, M.D. (Shishido Internal Medicine Clinic), Mie Shimizu, M.D. (Saiseikai Matsusaka General Hospital), Masanori Kawahara, M.D. Ph.D. (Soshukai Okabe Clinic), Shigeru Aoki, M.D. (Sakanoue Family Clinic), Akira Demizu, M.D. (Demizu Clinic), Masahiro Goshima, M.D., Ph.D. (Homecare-Clinic Kobe), Keiji Goto, M.D. (Himawari Zaitaku Clinic), Yasuaki Gyoda, M.D., Ph.D. (Kanamecyo Home Care clinic), Jun Hamano, M.D. (Division of Clinical Medicine, Faculty of Medicine, University of Tsukuba), Kotaro Hashimoto, M.D. (Fukushima Home Palliative Care Clinic), Sen Otomo, M.D. (Shonan International Village Clinic), Masako Sekimoto, M.D. (Sekimoto Clinic), Takemi Shibata,

M.D. (Kanwakeakurinikku • Eniwa), Yuka Sugimoto, M.D. (Sugimoto Homecare Clinic), Mikako Matsunaga, M.D. (Senri Pain Clinic), Yukihiro Takeda, M.D. (Hidamari Clinic), Takeshi Sasara, M.D. (Yuuaiikai Nanbu Hospital), Jun Nagayama, M.D. (Peace Clinic Nakai).

#### **Conflict of interest statement**

None of the authors has financial and personal relationships to declare.

#### **Role of the Funding Source**

This study was funded by the National Cancer Center Research and Development Fund (25-A-22). The sponsor played no role in study design; collection, analysis, and interpretation of the data; writing of the report and the decision to submit the paper for publication.



## References

- [1] Degner LF, Kristjanson LJ, Bowman D, Sloan JA, Carriere KC, O'Neil J, et al. Information needs and decisional preferences in women with breast cancer. *JAMA* 1997;277:1485–92.
- [2] Steinhauser KE, Christakis NA, Clipp EC, McNeilly M, McIntyre L, Tulsky JA. Factors considered important at the end of life by patients, family, physicians, and other care providers. *JAMA : The Journal of the American Medical Association* 2000;284:2476–82.
- [3] Kirk P, Kirk I, Kristjanson LJ. What do patients receiving palliative care for cancer and their families want to be told? A Canadian and Australian qualitative study. *BMJ (Clinical Research Ed)* 2004;328:1343. doi:10.1136/bmj.38103.423576.55.
- [4] Simmons CPL, McMillan DC, McWilliams K, Sande TA, Fearon KC, Tuck S, et al. Prognostic Tools in Patients With Advanced Cancer: A Systematic Review. *Journal of Pain and Symptom Management* 2017;53:962–970.e10. doi:10.1016/j.jpainsymman.2016.12.330.
- [5] Morita T, Tsunoda J, Inoue S, Chihara S. The Palliative Prognostic Index: a scoring system for survival prediction of terminally ill cancer patients. *Support Care Cancer* 1999;7:128–33.
- [6] Maltoni M, Nanni O, Pirovano M, Scarpi E, Indelli M, Martini C, et al. Successful validation of the palliative prognostic score in terminally ill cancer patients. Italian Multicenter Study Group on Palliative Care. *Journal of Pain and Symptom Management* 1999;17:240–7.
- [7] Gwilliam B, Keeley V, Todd C, Gittins M, Roberts C, Kelly L, et al. Development of Prognosis in Palliative care Study (PiPS) predictor models to improve prognostication in advanced cancer: prospective cohort study. *BMJ* 2011;343:d4920–d4920. doi:10.1136/bmj.d4920.
- [8] Maltoni M, Scarpi E, Pittureri C, Martini F, Montanari L, Amaducci E, et al. Prospective comparison of prognostic scores in palliative care cancer populations. *The Oncologist* 2012;17:446–54. doi:10.1634/theoncologist.2011-0397.
- [9] Glare P, Virik K, Jones M, Hudson M, Eychmuller S, Simes J, et al. A systematic review of physicians' survival predictions in terminally ill cancer patients. *BMJ (Clinical Research Ed)* 2003;327:195–8. doi:10.1136/bmj.327.7408.195.
- [10] Viganò A, Dorgan M, Buckingham J, Bruera E, Suarez-Almazor ME. Survival prediction in terminal cancer patients: a systematic review of the medical literature. *Palliat Med* 2000;14:363–74.
- [11] Hui D, Park M, Liu D, Paiva CE, Suh S-Y, Morita T, et al. Clinician prediction of

- survival versus the Palliative Prognostic Score: Which approach is more accurate? *European Journal of Cancer* 2016;64:89–95. doi:10.1016/j.ejca.2016.05.009.
- [12] Farinholt P, Park M, Guo Y, Bruera E, Hui D. A Comparison of the Accuracy of Clinician Prediction of Survival Versus the Palliative Prognostic Index. *Journal of Pain and Symptom Management* 2018;55:792–7. doi:10.1016/j.jpainsymman.2017.11.028.
- [13] Reid VL, McDonald R, Nwosu AC, Mason SR, Probert C, Ellershaw JE, et al. A systematically structured review of biomarkers of dying in cancer patients in the last months of life; An exploration of the biology of dying. *PLOS ONE* 2017;12:e0175123. doi:10.1371/journal.pone.0175123.
- [14] Taylor P, Crouch S, Howell DA, Dowding DW, Johnson MJ. Change in physiological variables in the last 2 weeks of life: An observational study of hospital in-patients with cancer. *Palliative Medicine* 2015;29:120–7. doi:10.1177/0269216314554967.
- [15] Hui D, dos Santos R, Chisholm G, Bansal S, Silva TB, Kilgore K, et al. Clinical signs of impending death in cancer patients. *The Oncologist* 2014;19:681–7. doi:10.1634/theoncologist.2013-0457.
- [16] Hui D, Dos Santos R, Chisholm G, Bansal S, Souza Crovador C, Bruera E. Bedside clinical signs associated with impending death in patients with advanced cancer: preliminary findings of a prospective, longitudinal cohort study. *Cancer* 2015;121:960–7. doi:10.1002/ncr.29048.
- [17] Hui D, Hess K, dos Santos R, Chisholm G, Bruera E. A diagnostic model for impending death in cancer patients: Preliminary report. *Cancer* 2015;121:3914–21. doi:10.1002/ncr.29602.
- [18] Collins GS, Reitsma JB, Altman DG, Moons KGM. Transparent Reporting of a multivariable prediction model for Individual Prognosis Or Diagnosis (TRIPOD): The TRIPOD Statement. *Annals of Internal Medicine* 2015;162:55. doi:10.7326/M14-0697.
- [19] Chen Y-T, Ho C-T, Hsu H-S, Huang P-T, Lin C-Y, Liu C-S, et al. Objective Palliative Prognostic Score Among Patients With Advanced Cancer. *Journal of Pain and Symptom Management* 2015;49:690–6. doi:10.1016/j.jpainsymman.2014.08.017.
- [20] Uneno Y, Taneishi K, Kanai M, Okamoto K, Yamamoto Y, Yoshioka A, et al. Development and validation of a set of six adaptable prognosis prediction (SAP) models based on time-series real-world big data analysis for patients with cancer receiving chemotherapy: A multicenter case crossover study. *PLOS ONE* 2017;12:e0183291. doi:10.1371/journal.pone.0183291.
- [21] Baba M, Maeda I, Morita T, Inoue S, Ikenaga M, Matsumoto Y, et al. Survival

- prediction for advanced cancer patients in the real world: A comparison of the Palliative Prognostic Score, Delirium-Palliative Prognostic Score, Palliative Prognostic Index and modified Prognosis in Palliative Care Study predictor model. *European Journal of Cancer* 2015;51:1618–29. doi:10.1016/j.ejca.2015.04.025.
- [22] Templeton AJ, McNamara MG, Ceruga B, Vera-Badillo FE, Aneja P, Ocana A, et al. Prognostic Role of Neutrophil-to-Lymphocyte Ratio in Solid Tumors: A Systematic Review and Meta-Analysis. *JNCI Journal of the National Cancer Institute* 2014;106:dju124-dju124. doi:10.1093/jnci/dju124.
- [23] Zhang C, Wang H, Ning Z, Xu L, Zhuang L, Wang P, et al. Prognostic nutritional index serves as a predicative marker of survival and associates with systemic inflammatory response in metastatic intrahepatic cholangiocarcinoma. *OncoTargets and Therapy* 2016;Volume 9:6417–23. doi:10.2147/OTT.S112501.
- [24] Templeton AJ, Ace O, McNamara MG, Al-Mubarak M, Vera-Badillo FE, Hermanns T, et al. Prognostic Role of Platelet to Lymphocyte Ratio in Solid Tumors: A Systematic Review and Meta-Analysis. *Cancer Epidemiology Biomarkers & Prevention* 2014;23:1204–12. doi:10.1158/1055-9965.EPI-14-0146.
- [25] Royston P, Altman DG. Regression Using Fractional Polynomials of Continuous Covariates: Parsimonious Parametric Modelling. *Applied Statistics* 1994;43:429–67. doi:10.2307/2986270.
- [26] Buck K, Vrieling A, Zaineddin AK, Becker S, Hüsing A, Kaaks R, et al. Serum Enterolactone and Prognosis of Postmenopausal Breast Cancer. *Journal of Clinical Oncology* 2011;29:3730–8. doi:10.1200/JCO.2011.34.6478.
- [27] Gémes K, Malmo V, Laugsand LE, Loennechen JP, Ellekjaer H, László KD, et al. Does Moderate Drinking Increase the Risk of Atrial Fibrillation? The Norwegian HUNT (Nord - Trøndelag Health) Study. *Journal of the American Heart Association* 2017;6:e007094. doi:10.1161/JAHA.117.007094.
- [28] Cheon S, Agarwal A, Popovic M, Milakovic M, Lam M, Fu W, et al. The accuracy of clinicians' predictions of survival in advanced cancer: a review. *Annals of Palliative Medicine* 2016;5:22–9. doi:10.3978/j.issn.2224-5820.2015.08.04.
- [29] Mori M, Morita T, Igarashi N, Shima Y, Miyashita M. Communication about the impending death of patients with cancer to the family: a nationwide survey. *BMJ Supportive & Palliative Care* 2018;bmjspcare-2017-001460. doi:10.1136/bmjspcare-2017-001460.
- [30] Hui D, De La Cruz M, Mori M, Parsons HA, Kwon JH, Torres-Vigil I, et al. Concepts and definitions for “supportive care,” “best supportive care,” “palliative care,” and “hospice care” in the published literature, dictionaries, and textbooks. *Supportive*

Care in Cancer 2013;21:659–85. doi:10.1007/s00520-012-1564-y.

**Table 1 Patients Characteristics**

|   | All patients (n=2426) |      | Analyzed patients (n=1039) |      |
|---|-----------------------|------|----------------------------|------|
|   | Mean                  | S.D. | Mean                       | S.D. |
| Age (yrs)                                   | 69.1                  | 12.8 | 67.7                       | 13.1 |
| Heart rate (beat/minute)                    | 85.8                  | 16.5 | 85.3                       | 16.5 |
| Respiratory rate (breath/minute)            | 16.0                  | 4.5  | 15.8                       | 4.4  |
|   | N                     | %    | N                          | %    |
| Male sex                                    | 1387                  | 57.2 | 627                        | 60.3 |
| Site of primary cancer                      |                       |      |                            |      |
| Lung  | 519                   | 21.4 | 259                        | 24.9 |
| Stomach/oesophagus                          | 326                   | 13.4 | 144                        | 13.9 |
| Colon/rectum/small intestine                | 293                   | 12.1 | 125                        | 12.0 |
| Pancreas                                    | 250                   | 10.3 | 111                        | 10.7 |
| Liver/Biliary system                        | 221                   | 9.1  | 90                         | 8.7  |
| Ovary/uterus                                | 139                   | 5.7  | 57                         | 5.5  |
| Kidney/renal pelvis/ureter/bladder/prostate | 162                   | 6.7  | 53                         | 5.1  |
| Breast                                      | 122                   | 5.0  | 51                         | 4.9  |
| Head and neck                               | 78                    | 3.2  | 37                         | 3.6  |
| Others                                      | 258                   | 10.6 | 112                        | 10.8 |
| Metastatic site                             |                       |      |                            |      |
| Anywhere                                    | 1927                  | 79.4 | 855                        | 82.3 |
| Liver                                       | 855                   | 35.2 | 403                        | 38.8 |
| Bone  | 723                   | 29.8 | 308                        | 29.6 |
| Lung  | 807                   | 33.3 | 349                        | 33.6 |
| Central nervous system                      | 278                   | 11.5 | 127                        | 12.2 |
| Dyspnoea                                    | 700                   | 28.9 | 281                        | 27.0 |
| Anorexia                                    | 1813                  | 74.7 | 784                        | 75.5 |
| Fatigue                                     | 1712                  | 70.6 | 745                        | 71.7 |
| Weight loss in the previous month           | 1589                  | 65.5 | 681                        | 65.5 |
| Karnofsky Performance Scale                 |                       |      |                            |      |
| $\geq 50$                                   | 1143                  | 47.1 | 490                        | 47.2 |
| 30-40                                       | 822                   | 33.9 | 346                        | 33.3 |
| 10-20                                       | 455                   | 18.8 | 200                        | 19.2 |
| ECOG-PS* <sup>1</sup>                       |                       |      |                            |      |
| 0-1   | 255                   | 10.5 | 122                        | 11.7 |
| 2   | 440                   | 18.1 | 204                        | 19.6 |
| 3   | 882                   | 36.4 | 357                        | 34.4 |
| 4   | 846                   | 34.9 | 353                        | 34.0 |
| Global Health                               |                       |      |                            |      |
| 1: extremely poor                           | 248                   | 10.2 | 106                        | 10.2 |
| 2   | 567                   | 23.4 | 257                        | 24.7 |
| 3   | 814                   | 33.6 | 316                        | 30.4 |

|  |                |             |      |             |      |
|--|----------------|-------------|------|-------------|------|
| 4  |                | 443         | 18.3 | 202         | 19.4 |
| 5-7: normal health                                 |                | 348         | 14.3 | 155         | 14.9 |
| Abbreviated Mental Test by physician-proxy ratings |                |             |      |             |      |
|  | $\leq 3$       | 623         | 25.7 | 267         | 25.7 |
| Clinical prediction of survival (wks)              |                |             |      |             |      |
| >12  |                | 472         | 19.5 | 228         | 21.9 |
| 11-12  |                | 144         | 5.9  | 66          | 6.4  |
| 7-10   |                | 437         | 18.0 | 196         | 18.9 |
| 5-6  |                | 300         | 12.4 | 113         | 10.9 |
| 3-4  |                | 611         | 25.2 | 238         | 22.9 |
| 1-2  |                | 455         | 18.8 | 196         | 18.9 |
| Anticancer treatment                               |                |             |      |             |      |
| Chemotherapy                                       |                | 539         | 22.2 | 259         | 24.9 |
| Hormone therapy                                    |                | 36          | 1.5  | 14          | 1.3  |
| Radiotherapy                                       |                | 128         | 5.3  | 58          | 5.6  |
| Survival period                                    |                |             |      |             |      |
|  | $\leq 7$ -day  | 334         | 14.1 | 141         | 14.1 |
|  | $\leq 14$ -day | 642         | 27.2 | 270         | 26.9 |
|  | $\leq 30$ -day | 1117        | 47.3 | 478         | 47.7 |
|  | $\leq 56$ -day | 1559        | 66.0 | 654         | 65.2 |
|  | $\leq 90$ -day | 1812        | 76.7 | 764         | 76.2 |
| Median survival (days; 25%, 75% tile)              |                | 33 (13, 84) |      | 33 (13, 85) |      |

\*1 ECOG-PS: Eastern Co-operative Oncology Group Performance Status

**Table 2 Laboratory data of the analyzed patients**

|                                | Mean  | S.D.  |
|--------------------------------|-------|-------|
| Leukocyte count ( $10^9/L$ )   | 9.35  | 6.20  |
| Neutrophil count ( $10^9/L$ )  | 7.61  | 5.71  |
| lymphocyte count ( $10^9/L$ )  | 0.97  | 0.68  |
| Platelet count ( $10^9/L$ )    | 234.1 | 123.0 |
| Urea (mg/dL)                   | 22.9  | 20.0  |
| Creatinine (mg/dL)             | 0.90  | 0.8   |
| Alanine aminotransferase (U/L) | 42.0  | 79.6  |
| Alkaline phosphatase (U/L)     | 691.4 | 828.6 |
| Total bilirubin (mg/dL)        | 1.65  | 3.91  |
| Lactate dehydrogenase (U/L)    | 461.4 | 638.2 |
| Albumin (g/dL)                 | 28.4  | 7.3   |
| C-reactive protein (mg/dL)     | 6.3   | 6.6   |

**Table 3 Variables used in each model**

| Estimated survival time | OPI-AC formula*6  | AUC*1 (95% CI)        |                       |                       |                       |
|-------------------------|---|-----------------------|-----------------------|-----------------------|-----------------------|
|                         |   | OPI-AC                | PiPS*2-B model        | PaPs*3 model          | SAP*4 model           |
| 7 days                  | Y=heart rate + urea + albumin   | 0.765 (0.658 - 0.872) |                       |                       |                       |
| 14 days                 | Y=heart rate + urea + albumin + respiratory rate + creatinine + (C-reactive protein) <sup>-1</sup>  | 0.806 (0.720 - 0.892) | 0.862 (0.837 - 0.888) |                       |                       |
| 30 days                 | Y=heart rate + (urea) <sup>-1</sup> + (urea) <sup>-2</sup> + albumin + (percentage of lymphocytes) <sup>-0.5</sup> + (total bilirubin) <sup>-0.5</sup> + (PLR*5) <sup>-2</sup>                    | 0.894 (0.836 - 0.953) |                       | 0.870 (0.848 - 0.892) | 0.742 (0.653 - 0.832) |
| 56 days                 | Y=heart rate + (log <sub>urea</sub> <sup>-2</sup> ) + (urea) <sup>-2</sup> + albumin + percentage of lymphocytes + (total bilirubin) <sup>-1</sup> + (PLR*5) <sup>3</sup> + lactate dehydrogenase | 0.897 (0.834 - 0.960) | 0.827 (0.800 - 0.853) |                       | 0.769 (0.680 - 0.859) |
| 90 days                 | Y=heart rate + (log <sub>urea</sub> <sup>-2</sup> ) + (urea) <sup>-2</sup> + albumin + neutrophil count + (total bilirubin) <sup>-0.5</sup> + (PLR*5) <sup>-2</sup> + lactate dehydrogenase       | 0.923 (0.860 - 0.986) |                       |                       | 0.819 (0.734 - 0.904) |

\*1 AUC: Area under the curve

\*2 PiPS: Prognosis in Palliative Care Study

\*3 PaPs: Palliative Prognostic Score

\*4 SAP: Set of six adaptable prognostic models

\*5 PLR: Platelet / lymphocyte ratio (platelet count divided by the lymphocyte count).

\*6 OPI-AC: Objective Prognostic Index



**Appendix 1 Characteristics of analyzed vs. non-analyzed patients**

|   | Analyzed patients (n=1039) |      | Non-analyzed patients (n=1387) |      | p value |
|---|----------------------------|------|--------------------------------|------|---------|
|   | Mean                       | S.D. | Mean                           | S.D. |         |
| Age (yrs)                                   | 67.7                       | 13.1 | 70.1                           | 12.6 | <0.001  |
| Heart rate (beats/minute)                   | 85.3                       | 16.5 | 86.1                           | 16.6 | 0.232   |
| Respiratory rate (breaths/minute)           | 15.8                       | 4.4  | 16.3                           | 4.5  | 0.014   |
|   | N                          | %    | N                              | %    |         |
| Male sex                                    | 627                        | 60.3 | 760                            | 54.8 | 0.007   |
| Site of primary tumor                       |                            |      |                                |      | 0.129   |
| Lung  | 259                        | 24.9 | 260                            | 18.7 |         |
| Stomach/esophagus                           | 144                        | 13.9 | 182                            | 13.1 |         |
| Colon/rectum/small intestine                | 125                        | 12.0 | 168                            | 12.1 |         |
| Pancreas                                    | 111                        | 10.7 | 139                            | 10.0 |         |
| Liver/Biliary tract                         | 90                         | 8.7  | 131                            | 9.4  |         |
| Ovary/uterus                                | 57                         | 5.5  | 82                             | 5.9  |         |
| Kidney/renal pelvis/ureter/bladder/prostate | 53                         | 5.1  | 109                            | 7.9  |         |
| Breast                                      | 51                         | 4.9  | 71                             | 5.1  |         |
| Head and neck                               | 37                         | 3.6  | 41                             | 3.0  |         |
| Others                                      | 112                        | 10.8 | 146                            | 10.5 |         |
| Metastatic sites                            |                            |      |                                |      |         |
| Multiple                                    | 855                        | 82.3 | 1072                           | 77.3 | 0.004   |
| Liver                                       | 403                        | 38.8 | 452                            | 32.6 | 0.003   |
| Bone  | 308                        | 29.6 | 415                            | 29.9 | 0.784   |
| Lung  | 349                        | 33.6 | 458                            | 33.0 | 0.875   |
| Central nervous system                      | 127                        | 12.2 | 151                            | 10.9 | 0.344   |
| Dyspnea                                     | 281                        | 27.0 | 419                            | 30.2 | 0.092   |
| Anorexia                                    | 784                        | 75.5 | 1029                           | 74.2 | 0.496   |
| Fatigue                                     | 745                        | 71.7 | 967                            | 69.7 | 0.301   |

|  |     |     |      |     |      |       |
|--|-----|-----|------|-----|------|-------|
| Weight loss in the previous month                  |     | 681 | 65.5 | 908 | 65.5 | 0.877 |
| Karnofsky Performance Scale                        |     |     |      |     |      | 0.811 |
| ≥50  |     | 490 | 47.2 | 653 | 47.1 |       |
| 30-40  |     | 346 | 33.3 | 476 | 34.3 |       |
| 10-20  |     | 200 | 19.2 | 255 | 18.4 |       |
| ECOG-PS* <sup>1</sup>                              |     |     |      |     |      | 0.064 |
|  | 0-1 | 122 | 11.7 | 133 | 9.6  |       |
|  | 2   | 204 | 19.6 | 236 | 17.0 |       |
|  | 3   | 357 | 34.4 | 525 | 37.9 |       |
|  | 4   | 353 | 34.0 | 493 | 35.5 |       |
| Global Health                                      |     |     |      |     |      | 0.072 |
| 1: extremely poor                                  |     | 106 | 10.2 | 142 | 10.2 |       |
| 2  |     | 257 | 24.7 | 310 | 22.4 |       |
| 3  |     | 316 | 30.4 | 498 | 35.9 |       |
| 4  |     | 202 | 19.4 | 241 | 17.4 |       |
| 5-7: normal health                                 |     | 155 | 14.9 | 193 | 13.9 |       |
| Abbreviated Mental Test by physician-proxy ratings |     |     |      |     |      |       |
|  | ≤3  | 267 | 25.7 | 356 | 25.7 | 0.992 |
| Clinical prediction of survival (wks)              |     |     |      |     |      | 0.015 |
| >12  |     | 228 | 21.9 | 244 | 17.6 |       |
| 11-12  |     | 66  | 6.4  | 78  | 5.6  |       |
| 7-10   |     | 196 | 18.9 | 241 | 17.4 |       |
| 5-6  |     | 113 | 10.9 | 187 | 13.5 |       |
| 3-4  |     | 238 | 22.9 | 373 | 26.9 |       |
| 1-2  |     | 196 | 18.9 | 259 | 18.7 |       |
| Anticancer therapy                                 |     |     |      |     |      |       |
| Chemotherapy                                       |     | 259 | 24.9 | 280 | 20.2 | 0.022 |
| Hormone therapy                                    |     | 14  | 1.3  | 22  | 1.6  | 0.563 |
| Radiotherapy                                       |     | 58  | 5.6  | 70  | 5.1  | 0.208 |

Survival period

|                |     |      |      |      |       |
|----------------|-----|------|------|------|-------|
| $\leq 7$ -day  | 141 | 14.1 | 193  | 14.2 | 0.927 |
| $\leq 14$ -day | 270 | 26.9 | 372  | 27.4 | 0.815 |
| $\leq 30$ -day | 478 | 47.7 | 639  | 47.0 | 0.749 |
| $\leq 56$ -day | 654 | 65.2 | 905  | 66.5 | 0.497 |
| $\leq 90$ -day | 764 | 76.2 | 1048 | 77.1 | 0.614 |

|                                  |             |             |
|----------------------------------|-------------|-------------|
| Median survival (days; 25%, 75%) | 33 (13, 85) | 34 (13, 83) |
|----------------------------------|-------------|-------------|

---

**\*1 ECOG-PS: Eastern Cooperative Oncology Group Performance Status**

Figure 1 Examples of using Objective Prognostic Index for advanced cancer for patient A

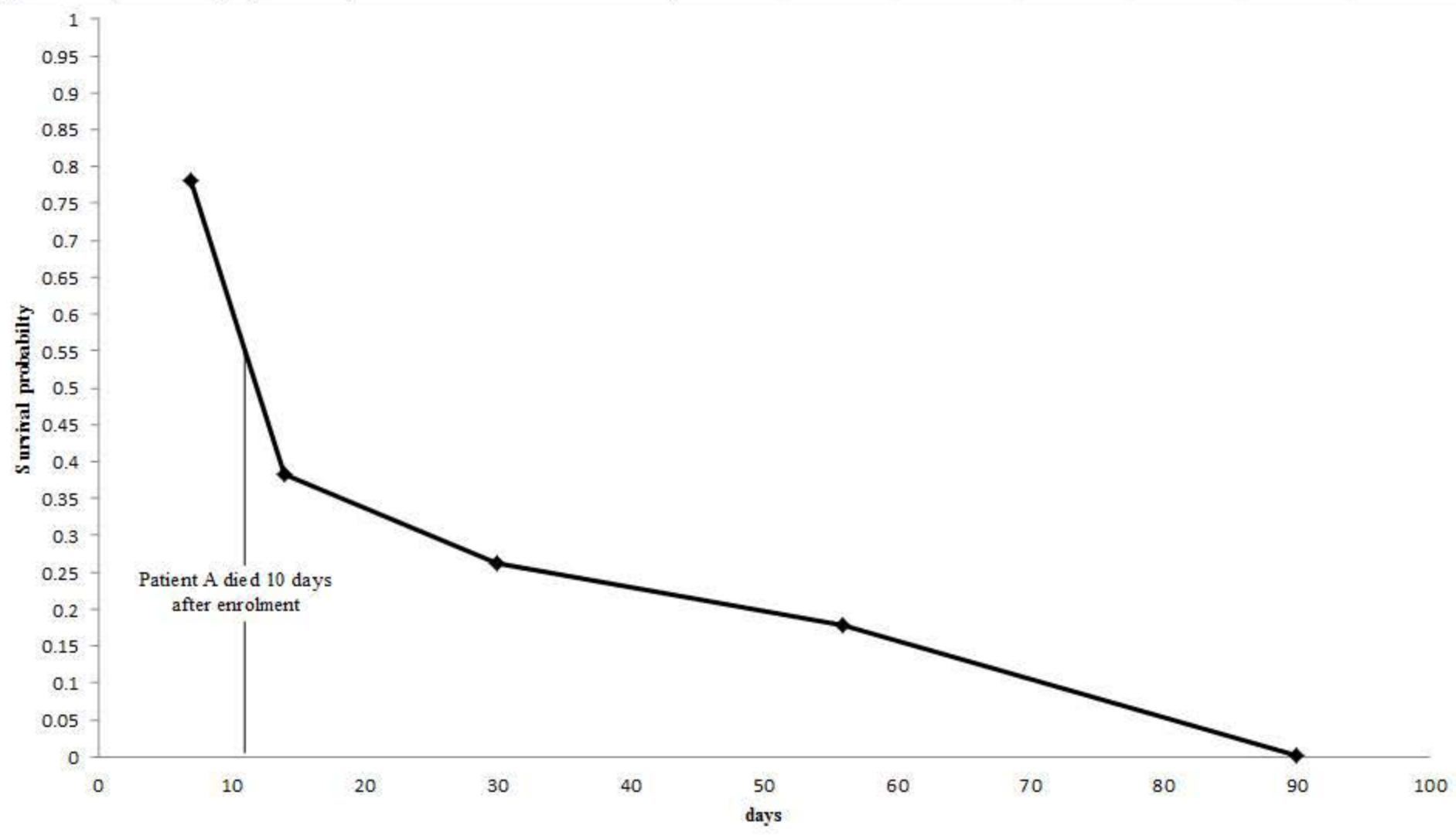


Figure 2 Examples of using Objective Prognostic Index for advanced cancer for patient B

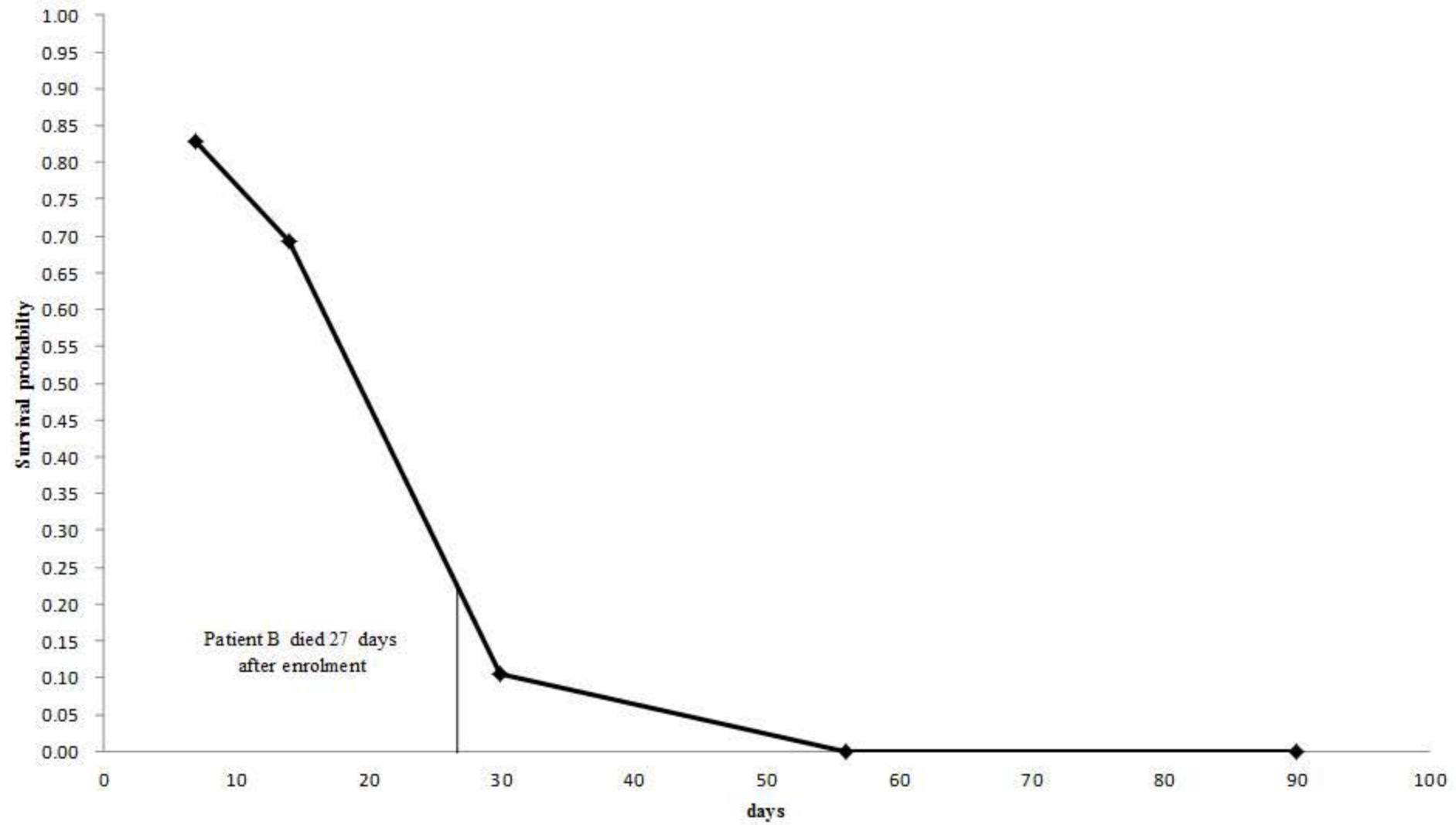
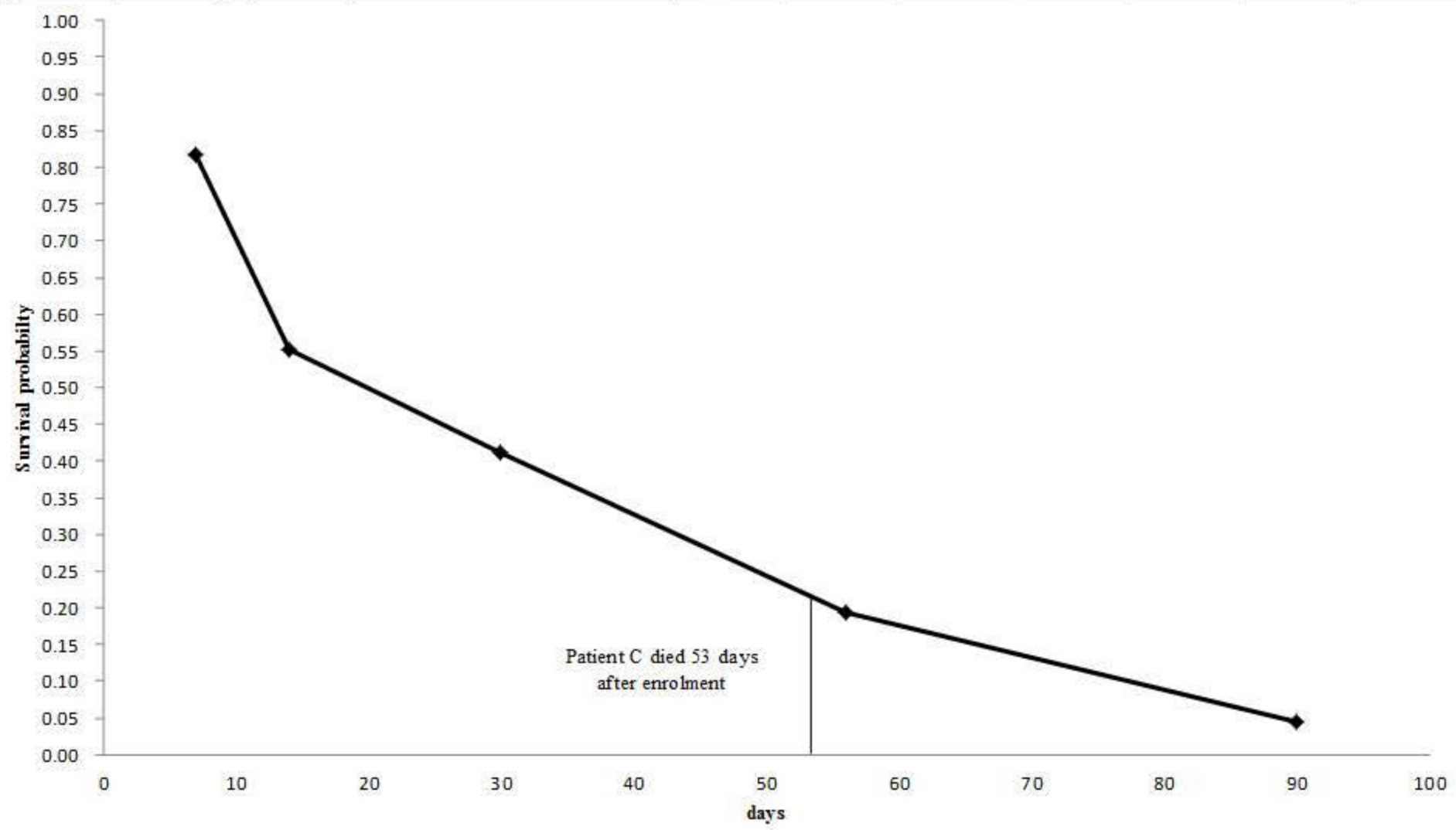


Figure 3 Examples of using Objective Prognostic Index for advanced cancer for patient C



## Figure Legends

### Figure 1

The variables for patient A were as follows: heart rate (78 beats/minute), respiratory rate (16 breaths/minute), neutrophil count ( $25.37 \times 10^9/L$ ), lymphocyte count ( $1.49 \times 10^9/L$ ), platelet count ( $317.0 \times 10^9/L$ ), urea (90.1 mg/dL), creatinine (1.89 mg/dL), total bilirubin (1.2 mg/dL), lactate dehydrogenase (343 U/L), albumin (2.4 g/dL), and C-reactive protein (18.3 mg/dL).

### Figure 2

The variables for patient B were as follows: heart rate (86 beats/minute), respiratory rate (16 breaths/minute), neutrophil count ( $6.27 \times 10^9/L$ ), lymphocyte count ( $0.90 \times 10^9/L$ ), platelet count ( $106.0 \times 10^9/L$ ), urea (9.0 mg/dL), creatinine (0.54 mg/dL), total bilirubin (2.6 mg/dL), lactate dehydrogenase (1594 U/L), albumin (2.6 g/dL), and C-reactive protein (5.2 mg/dL).

### Figure 3

The variables for patient C were as follows: heart rate (90 beats/minute), respiratory rate (15 breaths/minute), neutrophil count ( $8.67 \times 10^9/L$ ), lymphocyte count ( $0.88 \times 10^9/L$ ), platelet count ( $509.0 \times 10^9/L$ ), urea (13.0 mg/dL), creatinine (0.61 mg/dL), total bilirubin (1.0 mg/dL), lactate dehydrogenase (171 U/L), albumin (2.7 g/dL), and C-reactive protein (16.2 mg/dL).