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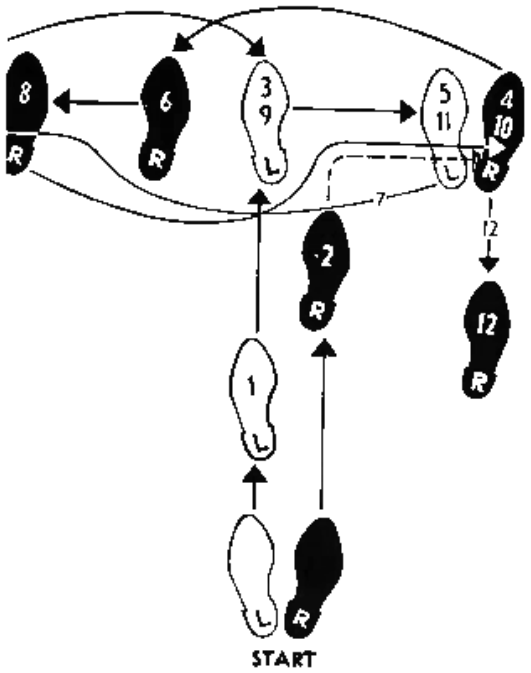
2022 NCITC Workshop:

Sample Size Determination- Methodology and Philosophy

Chris O'Callaghan and Greg Pond

Population, P-value and Power: Dancing the *"sample-size Tango"* of statistical inference in clinical research



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Learning Objectives

- Identify the key statistical components that drive sample sizes
- Discuss practical limitations and how to incorporate them in study design
- Discuss the ‘sample size tango’ for creating a successful sample size calculation

"How many do I need ?...."

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Sample Size in Medical Trials

"How many subjects are needed to assure a given probability of detecting a statistically significant effect, of a given magnitude, if one truly exists?"

What is the…

- smallest effect worth detecting?
  - Clinical relevance
- acceptable risk of "seeing it", if it doesn't exist?
  - Statistical significance level α, Type I error
- acceptable risk of missing it, if it exists?
  - Power β, Type II error (1-β)

Experimental Errors

Sample

Results of Statistical Analysis

	State of Nature (Reality) **UNKNOWN**	
	No Effect	Effect
No Effect	✓ 'Accept' null hypothesis when it is true	Type II (β) error 'Accept' null hypothesis when it is false
Effect	Type I (α, p) error Reject null hypothesis when it is true	✓ Reject null hypothesis when it is false

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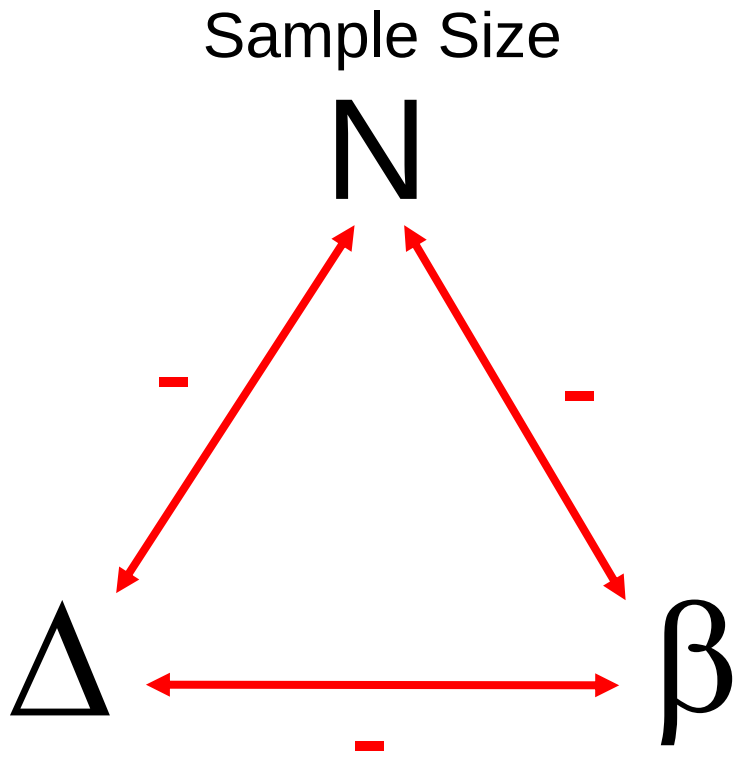
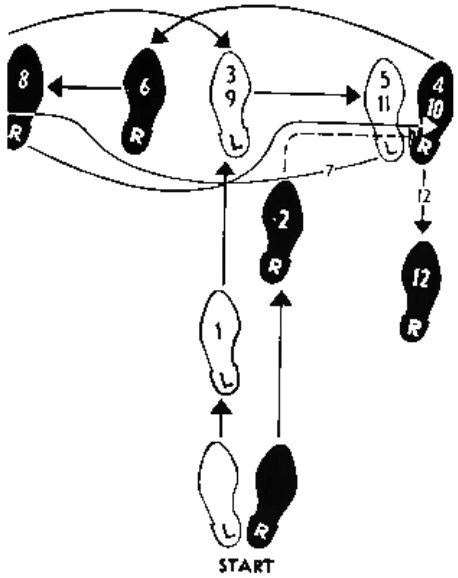
“The Tango”

α= 5%
Type I error
Statistical Significance





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Calculating a Sample Size

- The most difficult - and important - aspect of “sizing” a study is not the mathematics of sample size calculation…

- it’s deciding what the really relevant outcome measure is, what difference in that measure the trial will be designed to detect, and how this can be done in a timely fashion

Reference

Practical help for specifying the target difference in sample size calculations for RCTs: the DELTA five-stage study, including a workshop

JA Cook et al, Health Technology Assessment, 23(60): October 2019

BOX 3 The DELTA² recommendations for undertaking a sample size calculation and choosing the target difference

The following are recommendations for specifying the target difference in a RCT's sample size calculation when the conventional approach to the sample size calculation is used. Recommendations on the use (or not) of individual methods are made. More detailed advice on the application of the individual methods can be found elsewhere.[15]

Recommendations

- Begin by searching for relevant literature to inform the specification of the target difference. Relevant literature can:
  - relate to a candidate primary outcome and/or the comparison of interest
  - inform what is an important and/or realistic difference for that outcome, comparison and population (estimand of interest).
- Candidate primary outcomes should be considered in turn and the corresponding sample size explored. When multiple candidate outcomes are considered, the choice of primary outcome and target difference should be based on consideration of the views of relevant stakeholders groups (e.g. patients), as well as the practicality of undertaking such a study and the required sample size. The choice should not be based solely on which yields the minimum sample size. Ideally, the final sample size will be sufficient for all key outcomes, although this is not always practical.
- The importance of observing a particular magnitude of a difference in an outcome, with the exception of mortality and other serious adverse events, cannot be presumed to be self-evident. Therefore, the target difference for all other outcomes requires additional justification to infer importance to a stakeholder group.
- The target difference for a definitive (e.g. Phase III) trial should be one considered to be important to at least one key stakeholder group.
- The target difference does not necessarily have to be the minimum value that would be considered important if a larger difference is considered a realistic possibility or would be necessary to alter practice.
- When additional research is needed to inform what would be an important difference, the anchor and opinion-seeking methods are to be favoured. The distribution should not be used. Specifying the target difference based solely on a SES approach should be considered a last resort, although it may be helpful as a secondary approach.
- When additional research is needed to inform what would be a realistic difference, the opinion-seeking and review of the evidence-based methods are recommended. Pilot studies are typically too small to inform what would be a realistic difference and primarily address other aspects of trial design and conduct.
- Use existing studies to inform the value of key 'nuisance' parameters that are part of the sample size calculation. For example, a pilot trial can be used to inform the choice of SD value for a continuous outcome or the control group proportion for a binary outcome, along with other relevant inputs, such as the number of missing outcome data.
- Sensitivity analyses that consider the impact of uncertainty around key inputs (e.g. the target difference and the control group proportion for a binary outcome) used in the sample size calculation should be carried out.
- Specification of the sample size calculation, including the target difference, should be reported in accordance with the recommendations for reporting items (see *Chapter 4, Figure 1*) when preparing key trial documents (grant applications, protocols and result manuscripts).

SD, standard deviation; SES, standardised effect size.

Number of Events (d) Required

- Assume all the patients will have an event at the time of final analysis. We can determine number of events required:

$$H_0 : \Delta = 1 \; vs \; H_a : \Delta = \frac{\lambda_c}{\lambda_e} \neq 1$$

Statistical Significance

$$d = \frac{2\left(z_{\alpha/2} + z_{1-\beta}\right)^2}{\left(\ln \Delta\right)^2}$$

Power

Difference/Effect

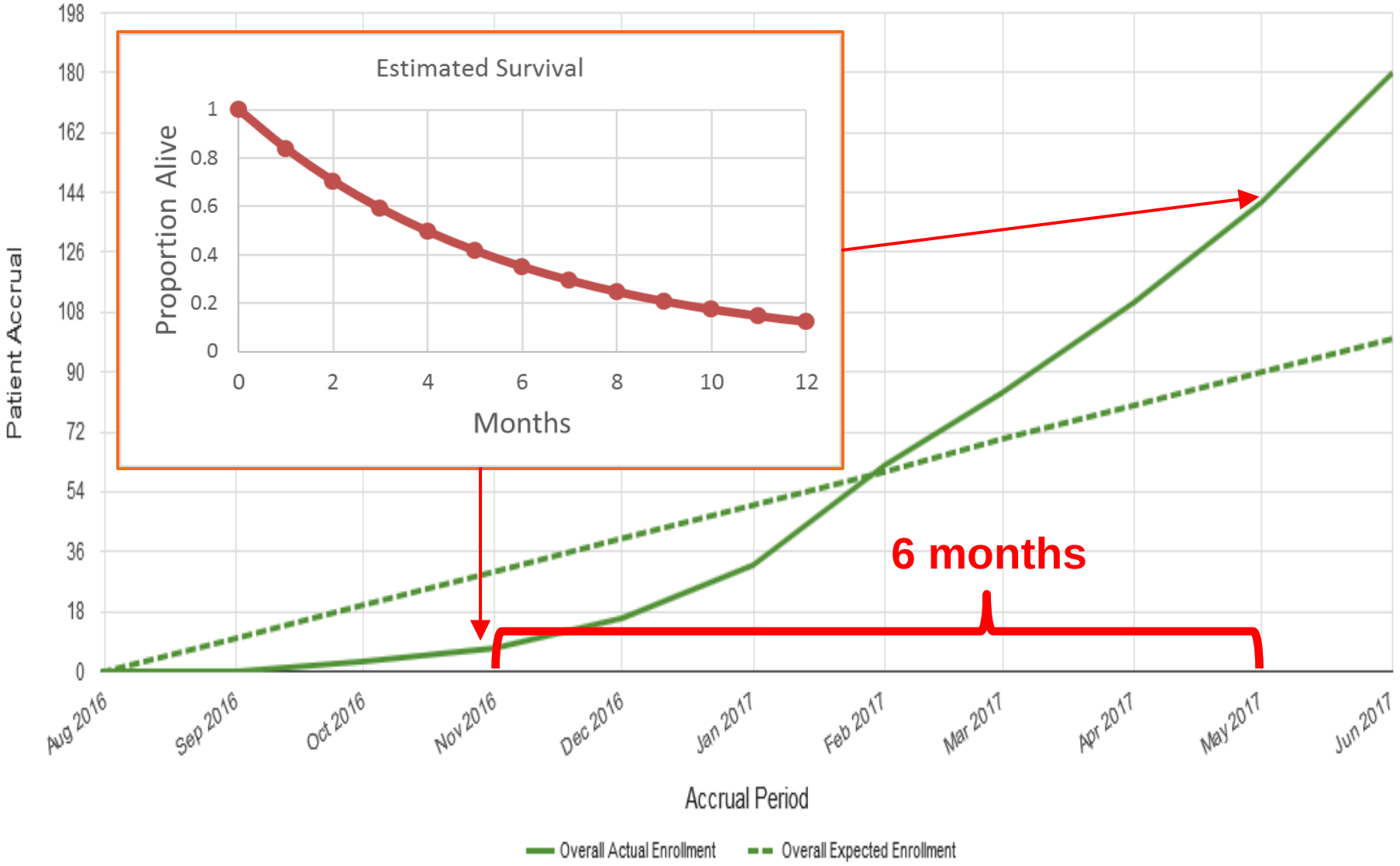
Example – Number of Events

- $H_0: S_e(t) = S_c(t)$ vs $H_a: S_e(t) \neq S_c(t)$
- M_e and M_c are median survivals of the experimental and control arms respectively

M_e	M_c	Δ (HR)	# Events
α=0.05, 1-β=0.8			
1.5	1	1.5	191
2.0	1	2.0	65
1.25	1	1.25	631
3.0	2	1.5	191
4.0	2	2.0	65

- Since there will be patients censored at the time of final analysis, we have to enter more patients and follow them for some time in order to observe the given number of events

Example: CO.26



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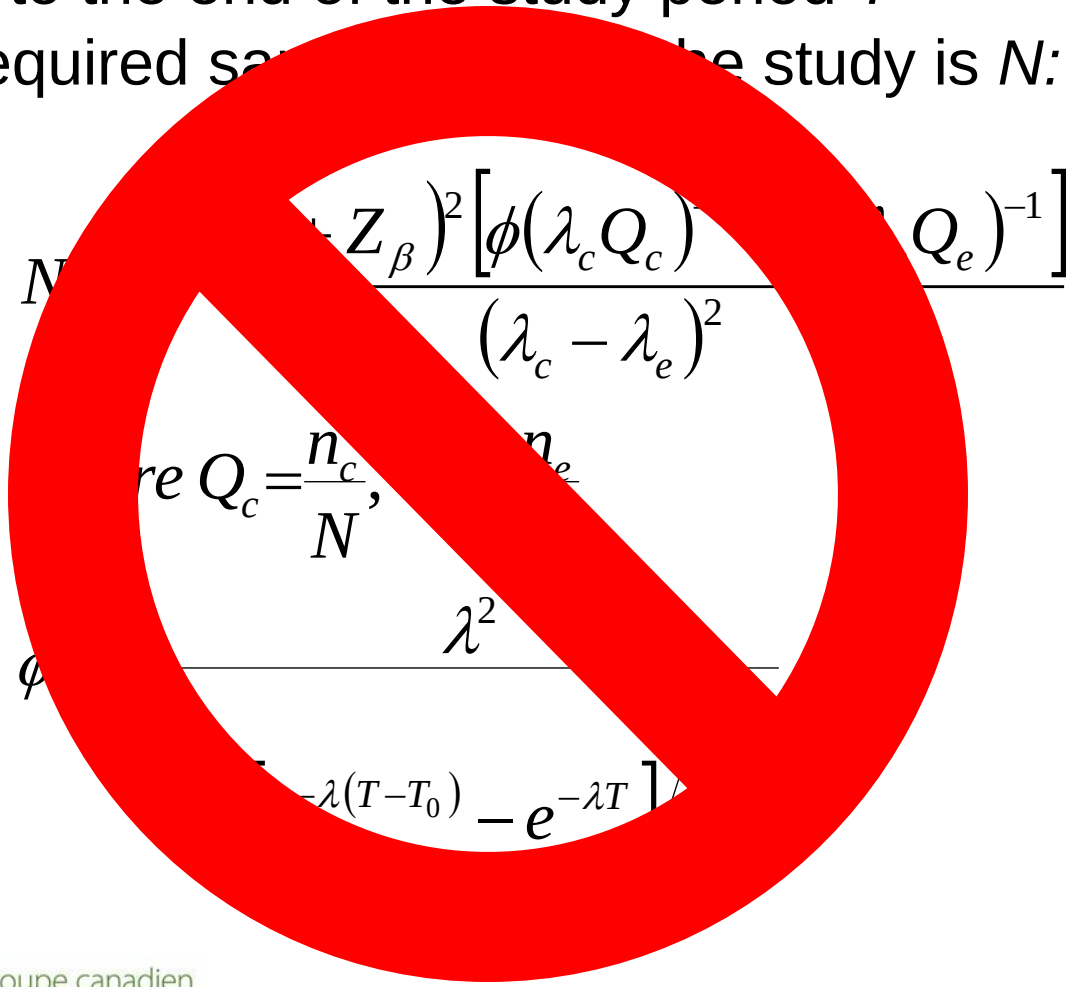
Total Size & Duration

- Patients are recruited over an interval *0* to T_0 and then follow to the end of the study period *T*
- The required sa… …e study is *N:*



Help is at hand!

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SWOG Cancer Research Network

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Two Arm Survival

Two Arm Survival is a program to calculate either estimates accrual or power for differences in survival times between two groups. The program allows for unequal sample size allocation between the two groups. The survival time estimates also allow for multiple strata or risk groups.

For further details, view the Help Document.

User Input	Program Output

Select Parameters

Type Calculation	Type Input	Sided
◉ Sample Size ○ Power	○ Hazard Ratio ○ Survival Proportions ◉ Medians	○ 1 Sided ◉ 2 Sided

Number Strata	Proportion in Standard Group	Alpha
1	0.5	0.05
Years of Accrual	**Years of Follow-up**	**Power**

Stratum	Proportion	Hazard Rate, Std.	Hazard Rate, Exp.	Hazard Ratio	Proportion Surviving, Std.	Survival Time, Std.	Proportion Surviving, Exp.	Survival Time, Exp.
1	1				0.5		0.5	

Accrual Rate	Total Accrual

Calculate

Help Document

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Two Arm Survival (crab.org)

A PHASE III RANDOMIZED STUDY OF YTTRIUM-90 GLASS MICROSPHERES PLUS BEST SUPPORTIVE CARE VERSUS BEST SUPPORTIVE CARE ALONE IN PATIENTS WITH PRETREATED LIVER-DOMINANT METASTATIC COLORECTAL CARCINOMA

- Primary Outcome = Survival
- 1:1 Randomization
- Alpha = 0.05, 2-sided
- Power = 90%
- Median Survival Control = 6 months
- Hazard Ratio to Detect = 1.25 (0.80)
- 6 months – 7.5 months
- 845 events required
- Accrual Rate = 100 / year
- Duration of Follow-up = 6 months

= 890

- Accrued over ~ 9 years
- Total duration ~ 9.5 years

- Primary Outcome = Survival
- 1:1 Randomization
- Alpha = 0.05, **1-sided ↓**
- Power = **80% ↓**
- Median Survival Control = 6 months
- Hazard Ratio to Detect = **1.50(0.67)↑**
- 6 months – **9 months ↑**
- 151 events required
- Accrual Rate = 100 / year
- Duration of Follow-up = **18 months ↑**

= 166

- Accrued over ~ 1.67 years
- Total duration ~ 3.33 years

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Another Example of "the Tango"…

- Adjuvant trial in resected biliary cancer evaluating capecitabine vs capecitabine + gemcitabine
- Primary endpoint Relapse-Free Survival (RFS)
- 1:1 randomization
- Alpha = 5%, 2-sided (Type I error)
- Power = 80% (Type II error = 20%)
- Median RFS with capecitabine = 24 months
- Hazard Ratio = 1.4 (/0.714 or 28.6% reduction in risk of relapse)
  - Median RFS with combination = 33.6 months
  - Absolute improvement in median of 9.6 months

278 "Events" Required

$$d = \frac{2\left(z_{\alpha/2} + z_{1-\beta}\right)^2}{\left(\ln \Delta\right)^2}$$

How do we get 278 events?

Need to know accrual RATE!

Accrue at 18 patients per month (~216 per year):

a) Accrue for 2 years to enroll 422 patients then follow for an additional 2.75 years = Total Duration of 4.75 years (66%)

b) Accrue for 1.5 years to enroll 320 patients then follow for an additional 6.25 years = Total Duration of 7.75 years (87%*)

c) Accrue for 3 years to enroll 659 patients then follow for an additional 0.5 years = Total Duration of 3.5 years (42%)

* CAUTION – Assumes constant risk and therefore exponential distribution

Fill in the Blanks!

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For further details, view the Help Document.

User Input	Program Output

Select Parameters

Type Calculation	Type Input	Sided
(•) Sample Size ( ) Power	( ) Hazard Ratio ( ) Survival Proportions (•) Medians	( ) 1 Sided (•) 2 Sided

Number Strata	Proportion in Standard Group	Alpha
1	0.5	0.05
Years of Accrual	**Years of Follow-up**	**Power**
2	**2.75**	**0.80**

Stratum	Proportion	Hazard Rate, Std.	Hazard Rate, Exp.	Hazard Ratio	Proportion Surviving, Std.	Survival Time, Std.	Proportion Surviving, Exp.	Survival Time, Exp.
1	1	0.347	0.248	1.4	0.5	**2**	0.5	**2.8**

Accrual Rate	Total Accrual
211.48	422

Calculate

Help Document

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Two Arm Survival (crab.org)

“Too optimistic…”

- Adjuvant trial in resected biliary cancer evaluating capecitabine vs capecitabine + gemcitabine
- Primary endpoint Relapse-Free Survival (RFS)
- 1:1 randomization
- Alpha = 5%, 2-sided (Type I error)
- Power = 80% (Type II error = 20%)
- Median RFS with capecitabine = 24 months
- Hazard Ratio = **1.3** (/0.769 or 23.1% reduction in risk of relapse)
- Median RFS with combination of **31.2** months
- Absolute improvement in median of **7.2** months

457 “Events” Required

29% to 23% risk reduction = 278 to 457 Events

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How do we get 457 events?

Accrue at 18 patients per month (~216 per year):

a) Accrue for 3 years to enroll 640 patients then follow for an additional 2.75 years = Total Duration of 5.75 years (71%)

b) Accrue for 2.5 years to enroll 534 patients then follow for an additional 5.25 years = Total Duration of 7.75 years (86%*)

c) Accrue for 4 years to enroll 850 patients then follow for an additional 0.75 years = Total Duration of 4.75 years (54%)

"Too optimistic…"

Accrue at **10 patients per month** (120 per year):

a) Accrue for 4.5 years to enroll 538 patients then follow for an additional 4.25 years = Total Duration of 8.75 years (85%*)

b) Accrue for 4 years to enroll 482 patients then follow for an additional 8 years = Total Duration of 12 years (95%*)

c) Accrue for 6 years to enroll 693 patients then follow for an additional 1 year = Total Duration of 7 years (66%)

d) Accrue for 5 years to enroll 589 patients then follow for an additional 2.75 years = Total Duration of 7.75 years (78%)

The Dance Continues!