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TABLE OF CONTENTS

HEADER	1
ABSTRACT	1
PLAIN LANGUAGE SUMMARY	2
BACKGROUND	3
OBJECTIVES	5
METHODS	5
RESULTS	14
Figure 1.	15
Figure 2.	17
Figure 3.	18
Figure 4.	20
Figure 5.	25
Figure 6.	27
Figure 7.	28
Figure 8.	29
Figure 9.	31
Figure 10.	32
Figure 11.	33
Figure 12.	35
Figure 13.	36
Figure 14.	37
Figure 15.	39
Figure 16.	40
Figure 17.	41
DISCUSSION	43
AUTHORS' CONCLUSIONS	44
ACKNOWLEDGEMENTS	44
REFERENCES	46
CHARACTERISTICS OF STUDIES	63
ADDITIONAL TABLES	95
APPENDICES	126
Figure 18.	144
Figure 19.	145
Figure 20.	146
Figure 21.	147
Figure 22.	148
Figure 23.	162
Figure 24.	163
Figure 25.	164
Figure 26.	165
Figure 27.	166
Figure 28.	167
Figure 29.	168
Figure 30.	169
Figure 31.	170
Figure 32.	171
Figure 33.	172
Figure 34.	173
Figure 35.	174
WHAT'S NEW	214
CONTRIBUTIONS OF AUTHORS	214

DECLARATIONS OF INTEREST	214
SOURCES OF SUPPORT	215
DIFFERENCES BETWEEN PROTOCOL AND REVIEW	215
INDEX TERMS	215

[Intervention Review]

Erythropoietin or Darbepoetin for patients with cancer - meta-analysis based on individual patient data

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ABSTRACT

Background

Erythropoiesis-stimulating agents (ESAs) reduce anemia in cancer patients and may improve quality of life, but there are concerns that ESAs might increase mortality.

Objectives

Our objectives were to examine the effect of ESAs and identify factors that modify the effects of ESAs on overall survival, progression free survival, thromboembolic and cardiovascular events as well as need for transfusions and other important safety and efficacy outcomes in cancer patients.

Search methods

We searched the Cochrane Library, Medline, Embase and conference proceedings for eligible trials. Manufacturers of ESAs were contacted to identify additional trials.

Selection criteria

We included randomized controlled trials comparing epoetin or darbepoetin plus red blood cell transfusions (as necessary) versus red blood cell transfusions (as necessary) alone, to prevent or treat anemia in adult or pediatric cancer patients with or without concurrent antineoplastic therapy.

Data collection and analysis

We performed a meta-analysis of randomized controlled trials comparing epoetin alpha, epoetin beta or darbepoetin alpha plus red blood cell transfusions versus transfusion alone, for prophylaxis or therapy of anemia while or after receiving anti-cancer treatment. Patient-level data were obtained and analyzed by independent statisticians at two academic departments, using fixed-effects and random-effects meta-analysis. Analyses were according to the intention-to-treat principle. Primary endpoints were on study mortality and overall survival during the longest available follow-up, regardless of anticancer treatment, and in patients receiving chemotherapy. Tests for interactions were used to identify differences in effects of ESAs on mortality across pre-specified subgroups. The present review reports only the results for the primary endpoint.

Main results

A total of 13933 cancer patients from 53 trials were analyzed, 1530 patients died on-study and 4993 overall. ESAs increased on study mortality (combined hazard ratio [cHR] 1.17; 95% CI 1.06-1.30) and worsened overall survival (cHR 1.06; 95% CI 1.00-1.12), with little heterogeneity between trials (I^2 0%, $p=0.87$ and I^2 7.1%, $p=0.33$, respectively). Thirty-eight trials enrolled 10441 patients receiving chemotherapy. The cHR for on study mortality was 1.10 (95% CI 0.98-1.24) and 1.04; 95% CI 0.97-1.11) for overall survival. There was little evidence for a difference between trials of patients receiving different cancer treatments (P for interaction=0.42).

Authors' conclusions

ESA treatment in cancer patients increased on study mortality and worsened overall survival. For patients undergoing chemotherapy the increase was less pronounced, but an adverse effect could not be excluded.

PLAIN LANGUAGE SUMMARY

Anti-anemia drugs shorten survival for some cancer patients

People with cancer may develop a blood problem called anemia, due to the treatment or from the disease itself. They will have very low levels of healthy red blood cells, causing additional health problems. For years, doctors have tried to prevent or treat anemia with injections of erythropoiesis stimulating agents (ESAs) in order to spare cancer patients the many serious harms associated with a red-blood cell transfusion (such as hepatitis, transfusion-related acute lung injury, infection). Earlier reviews of the research showed that ESA treatment reduces the need for transfusion but, in recent years, several studies have shown that ESAs themselves cause harm. The drug may, for example, stimulate tumor growth and cause potentially fatal blood clots. In 2007, new studies reported that ESAs shortens survival in people with breast, non-small cell lung, head and neck, lymphoid and cervical cancers.

A new systematic review was needed to evaluate the old and the new evidence together and determine the impact of ESAs on survival in cancer patients to see if there are groups of patients who are at increased or decreased risk compared to the average. To accomplish this the authors of this meta-analysis conducted an in-depth assessment of the individual patient data generated by the care of nearly 14,000 patients from 53 trials conducted worldwide. Data on each of these patients were provided by three companies that make ESAs: Amgen, Johnson & Johnson, and Roche, and by several independent researchers. (The drug companies, however, had no role in conducting the meta-analysis.) The trials investigated one of two types of ESAs, epoetin or darbepoetin, and compared the use of one of these drugs plus red blood cell transfusion (as needed), with red blood cell transfusion alone (as needed). Most patients were given their treatment while undergoing anti-cancer therapy (chemotherapy and/or radiotherapy); but others received the treatment after they had completed their anti-cancer therapy. Some patients already had anemia; others were treated in order to prevent it. The patients had many different forms of cancer and many different anti-cancer treatments.

The authors of this new meta-analysis concluded that ESA treatment shortens survival. They could not identify with certainty any subgroup of patients at either increased or decreased risk of dying when taking ESAs. With their doctors' help, cancer patients should consider the risks of taking ESA against the risks of a blood transfusion. Be aware, however, that uncertainties remain about the magnitude of each.

BACKGROUND

Description of the condition

Tumor anemia

Anemia is defined as a deficiency in red blood cells (RBC) and is a widely prevalent complication among cancer patients (Ludwig

2004). A commonly used classification of anemia according to hemoglobin levels (National Cancer Institute) is shown in the following table (Groopman 1999):

Category	Women	Men
Grade 0 (normal)	12.0 to 16.0 g/dl	14.0 to 18.0 g/dl
Grade 1 (mild)	10.0 to <12.0 g/dl	10.0 to <14.0 g/dl
Grade 2 (moderate)	8.0 to <10.0 g/dl	8.0 to <10.0 g/dl
Grade 3 (severe)	6.5 to <8.0 g/dl	6.5 to <8.0 g/dl
Grade 4 (life threatening)	<6.5 g/dl	<6.5 g/dl

The pathophysiology of tumor anemia is multifactorial (Spivak 2005). Tumor-associated factors such as tumor bleeding, hemolysis, deficiency in folic acid and vitamin B12, can be acute or chronic. In the advanced stages of hematological malignancies, bone marrow involvement often leads to progressive anemia. In addition, interaction between tumor-cell populations and the immune system can lead to the release of cytokines, especially interferon-gamma, interleukin-1 and tumor necrosis factor. This disrupts endogenous erythropoietin synthesis in the kidney and suppresses differentiation of erythroid precursor cells in the bone marrow. As a result, patients with tumor anemia may have relatively low levels of erythropoietin for the grade of anemia observed (Spivak 2005). Moreover, activation of macrophages can lead to a shorter erythrocyte half-life and a decrease in iron utilization. Cytostatic therapy and radiation further aggravates anemia in cancer patients. Platinum-based chemotherapy regimens may diminish endogenous erythropoietin production by damaging renal tubular cells (Wood 1995) and myelotoxic anticancer drugs can compromise erythroid precursor cells. As a consequence, dose-intensified treatment regimens or shortened treatment intervals as well as multimodal therapies are associated with a higher degree of anemia. Mild or moderate (grade 1 and 2) anemia in patients with solid cancers may affect about 60% of patients after platinum-based chemotherapy (Groopman 1999). Severe (grade 3) anemia in elderly patients with hematological malignancies may occur in up to 74% in patients with Non-Hodgkin lymphoma after standard CHOP treatment (Groopman 1999). In addition, some of the newer chemotherapeutic agents such as taxanes or vinorelbine are strongly myelosuppressive and frequently cause severe anemia (Groopman 1999).

The clinical manifestation and severity of anemia can vary considerably among individual patients. Mild to moderate anemia can typically cause signs and symptoms such as headache, palpitations, tachycardia and shortness of breath. Chronic anemia can result in severe organ damage affecting the cardiovascular system, immune system, lungs, kidneys and the central nervous system (Ludwig 2001). In addition to physical symptoms, the subjective impact of cancer-related anemia on quality of life (QoL),

mental health and social activities may be substantial. Clinical studies have reported correlations between hemoglobin (Hb) levels and QoL (Cella 1997; Holzner 2002; Lind 2002). A common anemia-related problem is fatigue, which impairs the patient's ability to perform normal daily activities (Ludwig 2001; Vogelzang 1997; Cramp 2008).

Another aspect of anemia in patients with malignant disease is the effect on the tumor itself. For several cancers, including cervical carcinoma, head and neck, prostate, bladder and lung cancer as well as lymphoma, anemia is known to be a factor associated with a worse prognosis (Caro 2001). This is partly due to confounding factors because advanced cancers usually present with lower Hb levels at diagnosis compared with early-stage cancers and also have poorer survival outcomes. Besides this, one causal explanation might be the improved oxygenation of tumor tissue at higher Hb levels. Since tumor cells become resistant by tumor hypoxia, improved oxygenation may prevent hypoxia maintaining tumor cells sensitive to radiation and most cytostatic drugs. Due to an abnormal microenvironment, solid tumor tissue is often hypoxic. Hypoxia may be more prevalent in anemic patients than in patients with normal Hb levels (Vaupel 2005). Tumor hypoxia may impair the effectiveness of radiotherapy and oxygen-dependent chemotherapies (Vaupel 2005; Schrijvers 1999; Hockel 1993). Anemia is associated with a poor outcome in patients treated with radiotherapy, most likely because anemia results in poor tumor oxygenation (Vaupel 2001). Radiobiological studies have shown that tumor hypoxia leads to less radiation induced cytotoxic free radicals resulting in less radiation-induced DNA damage and tumor cell kill. Tumor oxygenation is also impaired by hemoglobin levels >14 g/dl in women and >15 g/dl in men which result in increased viscosity and a drop in nutritive perfusion (Vaupel 2002). It was therefore suggested to keep the hemoglobin levels during radiotherapy within a potentially optimal range of 12-14 g/dl for women and 13-15 g/dl for men in order to achieve maximum tumor oxygenation (Vaupel 2002). These observations generated the hypothesis that strategies to diminish cancer-related anemia might not only alleviate anemia-related symptoms but also improve tumor response and overall survival.

Description of the intervention

Recombinant human erythropoietins

Conventionally, blood transfusions are used to treat severe cancer-related anemia. Homologous blood transfusion is the fastest method to alleviate symptoms. Potential complications include transmission of infectious diseases, transfusion reactions, alloimmunization, lung injury, over-transfusion and immune modulation with possible adverse effects on tumor growth (Goodnough 2005; Toy 2005). The risks of transfusion-related transmissions are 1:180,000 per units of blood transfused for hepatitis B virus, 1:1,600,000 for hepatitis C virus and 1:1,900,000 for HIV in the US (Goodnough 2003).

Short and long-acting preparations of recombinant human erythropoietins (ESAs) offer an alternative treatment option. Human erythropoietin is an acidic glycoprotein hormone and the primary regulator of human erythropoiesis. Human erythropoietin is mainly synthesized in the kidney and to a minor degree in the liver (Lai 1986; Koury 1991; Koury 1988). Tissue hypoxia triggers the synthesis and release of erythropoietin into the plasma. The effects of erythropoietin in the bone marrow are mediated by a specific surface erythropoietin receptor located mainly on RBC precursor cells (D'Andrea 1989). Erythropoietin has two major functions: stimulating proliferation of erythroid progenitor cells and maintaining their viability (Koury 1990). Recombinant human erythropoietin was first approved for the treatment of anemia in patients with chronic renal disease. In 1993, the use of erythropoietin was approved by the FDA for the treatment of anemia in cancer patients. Three different recombinant erythropoietins are available to date: epoetin alfa (Procrit®, OrthoBiotech; Epogen®, Amgen), epoetin beta (NeoRecormon®, Roche) and darbepoetin alfa (Aranesp®, Amgen). All three erythropoietins have similar clinical efficacy (Halstenson 1991; Storrington 1998; Glaspy 2005). Another substance called CERA® (Continuous Erythropoietin Receptor Activator, Roche) is currently being investigated in phase I and II clinical trials. Epoetin delta (Shire plc) differs from recombinant erythropoietins as it is produced in a human cell line using gene-activation technology. A randomized controlled trial of epoetin delta was recently presented (Zajda 2007).

How the intervention might work

Efficacy and safety

Multiple studies and subsequent meta-analyses have demonstrated that ESA treatment increases hemoglobin (Hb) levels and reduces the proportion of patients receiving red blood cell transfusions in cancer patients (Seidenfeld 2001; Bottomley 2002; Clark 2002; Bohlius 2006; Sehata 2007). In our previous meta-analysis including 42 studies with 6,510 patients the relative risk to receive RBC transfusions was 0.67 [95% confidence interval (CI) 0.60, 0.68] (Bohlius 2006).

Concern regarding the impact of ESAs on survival has been raised by several studies in oncology and hematology patients that have reported increased mortality in patients treated with ESAs (Leyland-Jones 2003; Henke 2003; Smith 2008; Hedenus 2003; Overgaard 2007; Wright 2007; Goss 2005). Three clinical studies reported increased tumor progression or death due to tumor progression in patients receiving ESAs (Henke 2003; Leyland-Jones 2003; Overgaard 2007). However, this effect was not consistently

observed and several studies did not show an increased risk for tumor progression for patients receiving ESAs (Machtay 2007; Chang 2005; EPO-GBR-7; Moebus 2007; Hedenus 2003). In addition, an increased risk for thromboembolic events has been consistently observed in various patient populations (Leyland-Jones 2003; Henke 2003; Thomas 2008; Goss 2005; Rosenzweig 2004; Smith 2008).

However, because erythropoietin receptors have been detected in numerous cancers (Arcasoy 2003; Arcasoy 2005; Dagnon 2005; McBroom 2005; Leo 2006), it is also possible that endogenously produced or exogenously administered erythropoietin promotes the proliferation and survival of erythropoietin receptor expressing cancer cells (Feldman 2006; Yasuda 2003; Mohyeldin 2005; Henke 2006). There is an ongoing debate about the validity of those studies, because the antibodies used most often lacked EPO-R specificity (Elliott 2006; Osterborg 2007). Thus, the interpretation of the observations made in many of those studies is questionable.

Besides this, other researchers have postulated an anti-apoptotic effect of ESAs on other tissues including neural (Brines 2004; Brines 2000) and cancer cells (Um 2007). In addition, it has been proposed that there is a link between endogenous erythropoietin and angiogenesis in vivo (Ribatti 2007b; Ribatti 2007a; Hardee 2007). Possibly, endogenous erythropoietin is needed to promote tumor angiogenesis and to maintain the viability of endothelial cells. However, the clinical implications of these findings have not been clarified to date. Apart from the direct tumor growth stimulation, a pathophysiological relationship between thromboembolic events and cancer has been described. Studies have implicated the tumor-mediated activation of the hemostatic system in both the formation of tumor stroma and in tumor metastasis (Francis 1998; Levine 2003).

In summary, a direct relationship between the presence of erythropoietin receptors on tumor cells and tumor proliferation in response to exogenous ESAs has not been established to date. Overall, the evidence from both in vitro and in vivo studies as well as clinical trials is insufficient to draw firm conclusions whether ESAs promote tumor proliferation or not.

Three Oncologic Drugs Advisory Committee (ODAC) hearings took place to discuss the safety of erythropoietins in cancer patients. After the first hearing in May 2004 the FDA concluded the Hb target for ESA treatment should not be higher than Hb 12 g/dL (Luksenburg 2004). Package inserts in the USA were amended to include this recommendation. Since then, another two randomized controlled trials showed detrimental effects for patients receiving ESAs. One study was conducted in patients with head and neck cancer undergoing radiotherapy (Overgaard 2007), another study was conducted with palliative intent for patients with advanced stage cancers not receiving chemotherapy (Smith 2008). The second ODAC hearing was held on May 10th 2007. In March 2007 a black box warning was added to the package inserts in the USA. This warning recommends that 1) ESAs should be used at the lowest dose that will gradually increase the Hb concentration to the lowest level sufficient to avoid the need for RBC transfusions, 2) ESAs should not be used in patients with active malignant disease not receiving chemotherapy or radiotherapy and 3) the target Hb should be 12 g/dL and not higher. In November 2007 another warning was released, declaring that "the risks of shortened survival and tumor progression have not been excluded when ESAs are dosed to target hemoglobin of < 12 g/dL." Following the release

of study data from two additional studies (Thomas 2008; Untch 2008), a third ODAC hearing was held in March 2008. At that meeting it was discussed whether the indication for ESAs in cancer patients receiving chemotherapy should be withdrawn, whether the drugs should not be used in cancer patient who are likely to be cured, which suggests the drugs should only be used as part of a best-supportive care regimen in patients with advanced cancer. It was also discussed that the drug should not be used in advanced or metastatic breast cancer as well as patients with head and neck cancer.

Why it is important to do this review

Rationale

We previously conducted a Cochrane Review on the effectiveness of ESAs which included trials published through 2001. This analysis suggested a survival benefit for patients receiving ESAs compared to patients only receiving red blood cell transfusions (hazard ratio (HR) 0.81, 95% confidence interval (CI) 0.67 to 0.99, $n = 2865$) (Bohlius 2005). This review was subsequently updated with studies published through April 2005. The updated review included 57 trials with 9353 patients (Bohlius 2006). In contrast to our previous findings, the results of the updated review suggested detrimental survival effects in patients receiving erythropoietin or darbepoetin compared to patients only receiving red blood cell transfusions (HR 1.08; 95%-CI 0.99-1.18; 42 trials, $n = 8167$) (Bohlius 2006). In addition, use of ESAs was statistically significantly associated with an increased risk for thromboembolic events (relative risk 1.67, 95%-CI 1.35-2.06; 35 trials, $n = 6769$) (Bohlius 2006).

However, to date it has not been convincingly shown whether ESA treatment increases or decreases tumor progression and overall survival. Risk factors to develop TEEs (thromboembolic events) under ESA treatment have not been identified yet.

The need for an individual patient data meta-analysis

The meta-analyses conducted so far are limited to published data aggregated across trials at the level of randomized groups (active treatment versus control). Pooled time-to-event analyses allow the examination of potential confounding and interaction, and are generally more efficient than analyses based on aggregated data. We therefore expanded our prior aggregated data meta-analysis to individual patient data (IPD). This will allow us to assess the associations between ESA treatment and risk for thromboembolic events, disease progression, quality of life and deaths in cancer patients and would provide a unique opportunity to shed light on the important questions discussed above.

OBJECTIVES

1. To examine the effect of ESAs on overall survival, progression free survival, thromboembolic and cardiovascular events as well as need for transfusions and other important safety and efficacy outcomes in cancer patients.
2. To identify factors that modify the effect of ESAs on overall survival, progression free survival, thromboembolic and cardiovascular events, need for transfusions and other important safety and efficacy outcomes in cancer patients.

METHODS

Criteria for considering studies for this review

Types of studies

In accordance with best practice in reviews of the effects of interventions, we included all eligible randomized controlled trials (Higgins 2006), for which individual patient data were available. Studies were included regardless of publication status, i.e. unpublished studies were included as well. We considered only studies that were planned to include at least 50 patients per study arm or at least 100 patients in total. Studies that were terminated prematurely and did therefore not reach the planned study size were included as well. A sensitivity analysis was conducted to test the influence of prematurely terminated studies. Placebo control was not required for inclusion but was recorded in the context of trial quality (see below). For the endpoints overall survival we included any eligible trial, regardless whether the study was designed for the endpoint survival or not.

Studies that did not collect or report data for any of the primary and secondary outcomes of this project (see below) were excluded. Ongoing studies, i.e. studies that were not completed according to the study specific protocol (e.g. complete follow-up for primary outcome), were included if the following criteria were met: recruiting phase completed, interim analyses conducted with in depth validation of the data, all initially randomized patients included in the interim analysis. Any other ongoing study was excluded from the present analysis but will be included in a later update of this analysis (e.g. German Hodgkin Study Group HD 15). Some studies offered ESA treatment to patients in the control arm after a defined period, e.g. after 12 weeks of study duration and allowed cross-over to the treatment arm after this defined period. For those studies we evaluated only the trial phase, where patients allocated to the control arm did not receive ESAs and patients allocated to the treatment arm received ESAs. For on study mortality we analyzed only data while the patient was on trial treatment plus a short follow-up period (four weeks or 28 days). For overall survival we collected the longest follow-up available, including the time after the end of study drug treatment.

Types of participants

Pediatric and adult, male and female patients with a clinically or histologically confirmed diagnosis of cancer receiving or not receiving chemotherapy or radiotherapy or combined modality treatment were included. Both patients with solid and hematological malignancies were eligible.

Studies on high-dose myeloablative chemotherapy regimens followed by bone marrow or peripheral blood stem cell transplantation, myelodysplastic syndromes or acute leukemia as well as trials using ESAs for short-term preoperative treatment were excluded. Studies were excluded if more than 20% of the entire patient population presents with an ineligible condition. However, if the respective study was randomized using a stratification technique and includes single strata that do fulfill the inclusion criteria, these strata were included in the analysis.

Types of interventions

Cancer patients in the experimental group must have received short or long acting ESAs to prevent or reduce anemia, given singly

or concomitantly with chemotherapy, radiotherapy, combination therapy or no therapy. ESAs had to be administered subcutaneously or intravenously. No minimum treatment duration or minimum ESA dosage was required for inclusion. Patients in both the control group and the experimental group(s) were to receive red blood cell transfusions if necessary. Studies with active controls i.e. head-to-head comparisons of different ESA types or dosages were excluded. Supportive care such as iron given either as necessary or following a fixed schedule was allowed. Apart from administration of ESAs, participants in experimental and control groups must have intended to receive identical care. For purposes of this analysis, patients receiving chemotherapy were considered to be receiving identical care, even if the regimens they received may have included different chemotherapy drugs. In the protocol we had stated that there was to be one exception: studies that compared ESA plus iron compared to no ESA and no iron were included. However, in the present review we also included two studies with different start of radiotherapy in the ESA and the control arm (Strauss 2008) and different transfusion trigger in the ESA and the control arm (Thomas 2008). The impact of these studies on the overall analysis was explored in a sensitivity analysis.

Types of outcome measures

Primary outcomes

On study mortality

Populations of interest, defined at study level (see below: Other definitions, Population of interest):

- cancer patients receiving chemotherapy or combined modality treatment regardless of Hb level
- all cancer patients receiving chemotherapy/combined modality treatment, radiotherapy/radio-chemotherapy or no anticancer treatment regardless of Hb level

Type of information: time-to-event, definition of event: death from any cause, starting time point: date of randomization, date of last follow-up to be considered: see Statistics section. A minimal follow-up time was not required for inclusion.

Overall survival

Populations of interest, defined at study level (see below: Other definitions, Population of interest):

- cancer patients receiving chemotherapy or combined modality treatment regardless of Hb level
- all cancer patients receiving chemotherapy/combined modality treatment, radiotherapy/radio-chemotherapy or no anticancer treatment regardless of Hb level

Type of information: time-to-event, definition of event: death from any cause, starting time point: date of randomization, date of last follow-up to be considered: longest follow-up available. A minimal follow-up time was not required for inclusion.

Secondary outcomes

On study mortality and overall survival

Populations of interest, defined at study level (see below: Other definitions, Population of interest):

- cancer patients receiving radiotherapy/radio-chemotherapy treatment regardless of Hb level
- cancer patients receiving no anticancer treatment regardless of Hb level

Note: these and all other secondary outcomes (not listed here) reported in the protocol (Bohlius 2008) were postponed and are not part of the present report. For details see protocol.

Other time points of interest

In addition to the time points specified above, we specifically examined the following points in time: 4, 8, 12, 24, 36, 60 months after randomization. These time points were calculated for the overall population as well as separately for the populations chemotherapy, radio(chemo)therapy, “mixed” and none.

Other definitions

Populations of interest

Highest priority was given to the analyses of cancer patients receiving concomitant chemotherapy and cancer patients receiving ESAs irrespective of concomitant anticancer treatment. The respective treatment strategies (chemotherapy/combined modality treatment versus radiotherapy/radiochemotherapy versus “mixed” versus no treatment) were explored in subset analyses. Note: the no treatment and the radio(chemo)therapy populations have not been analyzed separately.

Definitions of anticancer treatment populations: The definition of anticancer treatment populations was referring to the anticancer treatment at study level and not to the anticancer treatment an individual patient had actually received. A cut of 70% was chosen to define the different anticancer treatment populations at study level. I.e. if in a given study 70% of the patients had received chemotherapy, the study was classified as “chemotherapy population”. “Chemotherapy” refers to patients receiving a myelosuppressive chemotherapy. Combined modality treatment was defined as chemotherapy followed by radiotherapy. Radiochemotherapy was defined as treatment strategy where radiotherapy and chemotherapy were given at the same time. Radiotherapy was defined as population of patients receiving mainly radiotherapy only. “None” was defined as patients population were more than 70% of patients did not receive a myelosuppressive chemo/and or radiotherapy. Of note: “none” does not mean, that these patients did not receive any anticancer treatment. Patients in this population did receive corticosteroids, hormonal therapies, low dose chemotherapies and radiotherapies and other substances. However, this information is only available from the clinical study reports and the specific treatment per patient is not available.

Baseline variables

Hb and Hct

Baseline Hb and Hct were defined as Hb or Hct measurement up to 30 days before date of randomization or up to seven days after randomization.

Baseline age

Baseline age refers to age at date of randomization calculated based on the birth date provided per patient. For two studies

(Thomas 2008; Machtay 2007) birth dates were not reported; age at randomization or age at study entry was provided instead.

Other baseline variables

All other baseline values refer to the baseline as provided by the investigators.

Terminology

Subgroup and “subset” analyses

Any analyses that relate to information on the individual patient level are termed “subgroup analyses”. Any analyses that relate to information at study level are termed “subset analyses”.

“Missing” and “not reported” data

“Missing” means that the data were not provided in the requested standardized data format for this analysis, however, the data might be on file at the investigators’ site. “Not reported” means that the data are not on file at the investigators’ site.

Study numbers

A five digit study number was assigned randomly to each trial. A complete list of corresponding study numbers, study protocols and publications is on file and is not provided in this report.

Search methods for identification of studies

For the first and the updated version of this review (01/1985 to 12/2001 and 1/2002 to 04/2005) we identified relevant trials through electronic searches of the Cochrane Library, MEDLINE and EMBASE. For the planned IPD meta-analysis the same databases were searched for 2005 until December 2007. The first search was conducted in March 2007. The update search was conducted in January 2008. In addition, we searched relevant trials through searches of the conference proceedings of the American Society of Clinical Oncology, American Society of Hematology and European Society of Medical Oncology. Searches of conference proceedings were either done online, with CD-ROMs or by handsearching. For the present IPD meta-analysis we searched abstracts in the conference proceedings reported above for the years 2005 to end of 2007.

Reference lists of identified guidelines, systematic reviews and clinical trials were checked for additional information. Documents posted for the ODAC hearings in 2004 and 2007 were evaluated, documents posted for the ODAC hearing in March 2008 were not evaluated. Data bases of ongoing studies were searched as well. Previous searches of ongoing studies were updated to June 2007. Any accidentally identified trials were evaluated as well. Lists of identified studies were sent to the pharmaceutical companies who manufacture ESAs. Companies were asked to review and complete these lists. For a detailed description of the literature searches see below.

Electronic searches

For the individual patient data (IPD) meta-analysis on the effects of erythropoiesis-stimulating agents in cancer patients the results of electronic database search from two previous published reviews (Bohlius 2004; Bohlius 2006) which include the period 01/1985 to 12/2001 and 01/2002 to 9/2004 and an additional search which gives an update of published studies up to 12/2007 were used. A total of potential relevant hits 5546 (including duplicates caused by

an overlap of these three searches) identified from these literature databases. For search strategies see [Appendix 1](#).

Cochrane Review 2004

The first version of the Cochrane Review (Bohlius 2004) based on a main search period from 01/1985 to 12/2001.

Following databases are used:

- Cochrane Central Register of Controlled Trials Register (CENTRAL)
- MEDLINE (01/1985 to 12/2001)
- Cancer Lit (01/1985 to 12/2001)
- EMBASE (01/1985 to 12/2001)
- Medikat (01/1985 to 12/2001)
- Russmed Articles (01/1988 to 12/2001)
- SOMED (01/1985 to 12/2001)
- Toxline (01/1985 to 12/2001)
- BIOSIS Previews (01/1985 to 12/2001)
- LILACS (01/1986 to 12/2001)

The initial literature search in March 2002 retrieved 1,592 references.

Update Cochrane Review 2006

For the first update of the Cochrane Review (Bohlius 2006) the search strategy for epoetin alpha and beta was adapted from the previous Cochrane search strategy and run from 2000 until September 2004. In the case of darbepoetin alpha the search ran from 1996, the year before phase I studies were initiated on it. Searches ended in September 2004.

The following bibliographic databases were searched:

- Cochrane Central Register of Controlled Trials Register (CENTRAL) (01/2002 to 9/2004)
- MEDLINE (01/2002 to 9/2004)
- EMBASE (01/2002 to 9/2004)
- Science Citation Index (01/2002 to 9/2004)

In addition, all PubMed was screened on a daily basis by one reviewer (JB) until April 2005; all studies identified up to April 2005 were included in this review.

In addition to the initial literature search from March 2002, which retrieved 1,592 references, 1,859 references have been identified and screened.

Literature search update for the IPD meta-analysis

For this IPD meta-analysis additional database searches were performed for two periods.

The first search performed in March 2007 included all studies published later than 2000 until February 2007 (date of Index in database). The second search completed in January 2008 ensures an update of the information about available publications up to end of 2007.

The following bibliographic databases were searched:

- Cochrane Central Register of Controlled Trials Register (CENTRAL 01/2000 to 01/2008)
- MEDLINE (01/2000 to 12/2007)
- EMBASE (01/2005 to 12/2007)
- Science Citation Index (01/2000 to 12/2007)

This literature search retrieved 1,851 references for search conducted in March 2007 and 244 for the update search up to end of 2007 conducted in January 2008.

A total of 5546 hits (including duplicates caused by an overlap of these three searches) were identified from the literature databases. Out of the 5546 references identified 447 full text publications were retrieved for assessment.

Studies identified by database search

Thirty-two studies included in the IPD meta-analysis were identified by the database search:

[Aapro 2008](#); [Abels 1993](#); [Boogaerts 2003](#); [Case 1993](#); [Cazzola 1995](#); [Chang 2005](#); [Charu 2007](#); [Dammacco 2001](#); [Grote 2005](#); [Hedenus 2003](#); [Henke 2003](#); [Henry 1995](#); [Kotasek 2003](#); [Leyland-Jones 2003](#); [Littlewood 2001](#); [Machtay 2007](#); [O'Shaughnessy 2005](#); [Oberhoff 1998](#); [Osterborg 1996](#); [Osterborg 2002](#); [Pirker 2008](#); [Razzouk 2006](#); [Savonije 2005](#); [Smith 2008](#); [Strauss 2008](#); [Ten Bokkel Huinink 1998](#); [Thatcher 1999](#); [Thomas 2008](#); [Vansteenkiste 2002](#); [Wilkinson 2006](#); [Witzig 2005](#); [Wright 2007](#).

The other publications are additional references to already included or excluded studies (see 'Studies and references' table).

Searching other resources

Conference proceedings

For the first and the updated version of of the previously published Cochrane review ([Bohlius 2006](#)) we identified relevant studies through searches of the conference proceedings of the American Society of Clinical Oncology, American Society of Hematology and European Society of Medical Oncology (01/1985 to 12/2001 and 1/2002 to 04/2005). Searches of conference proceedings were either done online, with CD-ROMs or by handsearching.

For the IPD meta-analysis, we have searched the same conferences for the years 2005 to end of June 2007. The search was updated during the project in January 2008, extending the search to end of December 2007.

Handsearching was performed for the conference proceedings:

- European Hematology Association (2001 to 2007)
- American Society of Clinical Oncology (1989 to 1996)
- European Society of Medical Oncology (1989 to 2008)
- American Society of Hematology (1989 to 1997)

Electronic searching of the conference proceedings:

- Annual Meeting of the American Society of Clinical Oncology (1997 to 2008)
- Annual Meeting of the American Society of Hematology (1998 to 2008)

Out of 96 potential relevant abstracts from RCTs 21 studies fulfill the inclusion criteria of the IPD meta-analysis were published until

December 2007 and were identified by systematic screening of conference proceedings (ASCO, ASH, EHA and ESMO). The other abstract publications are additional references to already included or excluded studies (see 'Studies and references' section).

Thirteen studies are published as abstract only and eligible for the IPD meta-analysis:

[Gordon 2006](#); [Goss 2005](#); [Huddart 2002](#); [Kotasek 2002](#); [Moebus 2007](#); [Pronzato 2002](#); [Quirt 1996](#); [Ray-Coquard 2006](#); [Rose 1994](#); [Taylor 2005](#); [Thomas 2008](#); [Untch 2008](#); [Vadhan-Raj 2004](#).

Reference lists

The reference lists from following evidence based guidelines, systematic reviews and HTA reports were checked to identify potential relevant clinical studies:

Guidelines

ASCO / ASH 2007: [Rizzo 2008](#)

FNLCC 2007: Fédération nationale des centres de lutte contre le cancer. Recommandations pour la pratique clinique: Standards, Options et recommandations 2007 pour l'indication de l'agent stimulant l'érythropoïèse (ASE: époétine alpha, époétine bêta et darbepoétine) dans la prise en charge de l'anémie en cancérologie (Available: <http://www.fnclcc.fr/sor/structure/index-sorspecialistes.html>)

HTA Reports

[Seidenfeld 2006](#), [Wilson 2007](#)

Reviews

[Bennett 2008](#)

There was no additional relevant study identified.

ODAC documents

Documents posted for the ODAC hearings in 2004 and 2007 were evaluated. These documents include briefing document plus additional power point presentation prepared by medical reviewers of the Food and Drug Administration (FDA) and the companies Roche, Johnson & Johnson and Amgen. All of these documents are publicly available through the FDA briefing document at ODAC hearing 2004, briefing documents from FDA, Roche, Johnson & Johnson and Amgen:

Slides: <http://www.fda.gov/ohrms/dockets/ac/04/slides/4037s2.htm>,

Briefing documents: <http://www.fda.gov/ohrms/dockets/ac/04/briefing/4037b2.htm>

(Last time URL checked: 27 March 2009)

ODAC hearing 2007, briefing documents from FDA, Johnson & Johnson and Amgen

Slides: <http://www.fda.gov/ohrms/dockets/ac/07/slides/2007-4301s2-00-index.htm>

Briefing documents: <http://www.fda.gov/ohrms/dockets/ac/07/briefing/2007-4301b2-00-index.htm> (last time URL checked: 27 March 2009)

Following nine eligible studies primarily identified by screening of the FDA web sites:

EPO-GBR-7; EPO-CAN-15 (Goss 2005) ; EPO-CAN-20 (Wright 2007); GOG-191 (Thomas 2008); EPO-INT-1; EPO-INT-3; N93 004 (Grote 2005); CC2574-P-174; EPO-GER-22 (Debus 2006).

Five of them are published in meantime and also identified by systematic search of databases and abstracts:

- (EPO-CAN-15, 2004) (Goss 2005)
- (EPO-CAN-20, 2004) (Wright 2007)
- (EPO-GER-22, 2007) (Debus 2006)
- (GOG-191, 2004) (Thomas 2008)
- (N93 004, 2004) (Grote 2005)

Register of ongoing studies

Further potential relevant studies and ongoing trials identified by using the metaRegister of Controlled Trials (mRCT) <http://www.controlled-trials.com/> which include information of eight active registers. The last search was done June 30 2008 to allow an current status of the identified studies. The electronic search using the terms (epo* OR darb* OR erythrop* OR aranesp OR nesp* results in 671 hits, 95 of them are studies investigate ESAs in cancer patients. Forty-five studies fulfill the inclusion criteria for the IPD meta-analysis and 50 studies investigate ESA in cancer do not fulfill the inclusion criteria (intervention / control or disease). Out of the 45 studies which are potential eligible 22 can be assigned to at least one publication and 15 studies can not associated to any publication, 3 of 15 are stated as terminated. Further eight studies are declared as ongoing. For two trials interim results were published in local conferences (Debus 2006; Pronzato 2002).

Accidentally identified studies

Accidentally identified studies were evaluated as well.

Press release

One study (Untch 2008) was identified with a press release (Amgen 2007)

Contact with companies

Lists of identified completed and ongoing studies were sent to the pharmaceutical companies who manufacture ESAs. The three responsible companies Amgen, Hoffmann-LaRoche, Johnson & Johnson were asked to review and complete these lists:

- One additional reference (Milroy 2003) was identified in a list of trials conducted by the companies.
- Two previously not identified studies were also identified: (EPO-GER-20; OBE/EPO-INT-03)

Contact to authors

All authors of published RCTs were contacted to clarify the potential eligibility for the IPD meta-analysis (esp. the criterion on number of patients planned to be randomized).

Studies included in the IPD meta-analysis

Out of the different searches a total of 53 studies can be included in the meta-analysis of the effects of erythropoiesis-stimulating agents in cancer patients based on individual patient data.

Individual patient data are available and used from following 53 studies:

(EPO-GBR-7; EPO-INT-1; EPO-INT-3; CC2574-P-174; EPO-GER-20; OBE/EPO-INT-03; Aapro 2008; Abels 1993; Boogaerts 2003; Case 1993; Cazzola 1995; Chang 2005; Charu 2007; Dammacco 2001; Debus 2006; Gordon 2006; Goss 2005; Grote 2005; Hedenus 2003; Henke 2003; Henry 1995; Huddart 2002; Kotasek 2002; Kotasek 2003; Leyland-Jones 2003; Littlewood 2001; Machtay 2007; Milroy 2003; Moebus 2007; O'Shaughnessy 2005; Oberhoff 1998; Osterborg 1996; Osterborg 2002; Pirker 2008; Pronzato 2002; Quirt 1996; Ray-Coquard 2006; Razzouk 2006; Rose 1994; Savonije 2005; Smith 2008; Strauss 2008; Taylor 2005; Ten Bokkel Huinink 1998; Thatcher 1999; Thomas 2008; Thomas 2002; Untch 2008; Vadhan-Raj 2004; Vansteenkiste 2002; Wilkinson 2006; Witzig 2005; Wright 2007)

Data collection and analysis

Selection of studies

Trials identified through the update literature searches were screened independently by two reviewers (JB, OW) for the eligibility criteria stated previously. If eligibility could not be assessed satisfactorily from the title and abstract, a full text version was obtained for assessment. Studies that appeared to meet the inclusion criteria in the initial screening were further assessed for eligibility with the following questions:

Q1. Is the study described as randomized?

Q2. Did the participants in the study have a previously treated or untreated malignant disease?

Q3. Was one group given Epoetin-alfa or Epoetin-beta or Epoetin-delta or Darbepoetin-alfa or any other erythropoiesis-stimulating agent subcutaneously or intravenously?

Q4. Did the control group receive the same care (e.g. chemotherapy and supportive therapies) with or without placebo? Exception: iron, see Types of studies.

Q5. Did the study document any of the following outcomes: overall survival or thromboembolic / cardiovascular events or tumor progression or a similar endpoint or QoL measured with a validated instrument?

Q6. Did the study plan to include at least 50 patients per treatment arm or at least 100 patients in total?

Q7. Is the study completed by its own study protocol definition or has the study been terminated prematurely? For ongoing studies: is patient recruitment terminated and has a validated interim analysis been done? (see 'Criteria for considering studies for this review')

To be eligible, studies had to meet all of the criteria stated above. If there was insufficient information to judge eligibility, the first author of the report was contacted for clarification.

Studies excluded from the previous Cochrane Reviews were reassessed, because the eligibility criteria for the present IPD meta-analysis were not identical to those of the Cochrane Review. For example, studies with iron supplementation in one study arm only had been excluded from the previous Cochrane Reviews. Eligibility of these studies had to be reassessed for the present analysis. To assess Q6 (Did the study plan to include at least 50 patients per

treatment arm or at least 100 patients in total?) we contacted the sponsoring companies and independent investigators of studies that had evaluated less than 100 patients to clarify whether they had intended to include more than 100 patients. Lists of eligible studies were sent to the companies/investigators for confirmation of study eligibility. Studies evaluating less than 50 patients were excluded from the analysis. This criterion was discussed with the Steering Committee in January 2008 but had not been included in the final version of the protocol. If the two reviewers (JB, OW) could not reach consensus the principal investigator (AE) and the Steering Committee were involved. Any disagreements between the reviewers regarding eligibility were resolved by discussion.

Data extraction and management

Materials

The following documents were requested for each of the included studies

- Study protocol
- Clinical study report
- Case report form including Quality of Life instruments used
- Publications
- Individual patient data

Data sets had to include the individual patient data as defined for this project of all patients initially randomized.

Data Extraction and Compilation

Data submitted by the sponsors/investigators

Information were collected both at the level of the trial and at the patient level. The following study level characteristics were requested from the sponsors/independent investigators:

Study level information

Components of methodological quality, source of funding, completion of study, planned follow-up duration, duration of study, ESAs (type, dose, frequency and route of administration, criteria for stopping study drug), Hb/ hematocrit (Hct) target, policy regarding iron supplementation, planned and administered anticancer treatment.

Individual patient level information

Age, sex, type of tumor, type of antineoplastic therapy received (chemotherapy during ESA study yes/no/not reported, radiotherapy during ESA study yes/no/not reported), ESA dose received, red blood cell transfusions received, Hb and Hct values at baseline and during follow-up, date of death or date last time seen alive.

Based on these information additional variables were derived. A detailed list of variables including the coding scheme for each variable is on file.

Data extraction from available study documents

The investigators of the studies provided protocols, clinical study reports and case report forms for the included studies. For information at study level that was not provided by the investigators two reviewers (JB, SK) independently extracted the information from study protocols, clinical study reports, case

report forms and publications if necessary. Data extractions were compared and inconsistencies discussed until consensus was reached. If necessary, the sponsor or independent investigator submitting the data was contacted for clarification.

The following study characteristics were extracted:

- Was the study designed for long-term follow-up (defined as follow-up of at least 12 months after end of study phase)?
- Did the study have a prespecified cancer treatment protocol?
- Treatment category: chemotherapy, combined modality treatment, radiotherapy, radiochemotherapy, none or mixed.
- “cross-over”, i.e. whether patients in the control group were allowed to receive ESAs after a specified study period.

Data extraction not in duplicate

Data that were used for descriptive purposes in tables only and that were not used in any of the statistical analysis were extracted by one person only (JB).

Coding of the variable “metastatic disease”

For the present analysis we had requested two variables to describe the disease stage of the patients, i.e. whether the patient had extensive disease or metastatic disease or neither extensive nor metastatic disease. This simplified scheme did not work for the majority of trials and cancer types included and as a result for about 80% of patients we had no structured information on disease stage as requested. In addition, we had requested a free text entry describing the disease stage for each individual patient. Based on the free text entries and the available clinical study reports, for each patient the information “metastatic solid cancer or advanced hematological malignancies” yes versus no or not reported/unclear was assigned. The assignment was done by one reviewer (JB). The assigned categories were checked for consistency across trials in conjunction with the clinical study reports (JB).

The general coding rules were as follows:

Patients with solid cancers and metastatic disease or stage IV were coded as “metastatic”, all other patients were categorized as “non metastatic”. Patients with hematological malignancies in Ann Arbor stage III or IV were categorized as “advanced”; all other patients were categorized as “not advanced”. For patients with small cell lung cancer we differentiated “extensive disease” versus “limited disease”. If for a given study no information was available at patient level, but the clinical study report stated that for example all patients included in the study had metastatic disease, each patient of that particular study was coded as “metastatic”.

This procedure included several limitations; the main limitation is the inconsistency of tumor coding between trials. For some studies we received only the data entry “metastatic” and “non-metastatic” without specification of the TNM stages. In this case “metastatic” was classified “metastatic” for the coding system for the present analysis and “non-metastatic” was classified “other than metastatic for solid cancers”. For hematological malignancies “metastatic” was classified “advanced stage” and “non-metastatic” was classified “not advanced”. For other studies we received only TNM stages, e.g. stage I, II, III, or IV. However, not in all tumor types stage “IV” and “metastatic” are identical, i.e. only patients in stage IVB are metastatic whereas patients in stage IVA are not. Only for few cancer entities this problem does not exist, e.g. in breast cancer

all patients with stage IV are metastatic. This inconsistency between the coding in the different studies is a limitation of the current data set. However, the variables “metastatic” versus “non metastatic” serves as a proxy to see whether baseline imbalances or interaction between disease stage and study drug with effect on the outcome mortality exist.

Data management

Data were entered in a dedicated database. The format of the data requested is on file. Data were checked for accuracy, consistency, and completeness of follow-up (Stewart 1995). We used descriptive statistics to describe baseline characteristics of patients in each trial and to identify outliers. Accepted ranges for continuous variables were defined in advance. All data identified as missing, implausible or inconsistent were listed and sent to the investigators or company providing the data for the respective trial for clarification where possible. Overall survival and on study mortality of the different treatment groups in each trial were derived using the Kaplan-Meier method and standard Cox regression analysis and compared with published survival estimates. Any discrepancies between published data and provided individual patient data was reported to and discussed with the original investigator or company providing the data. A detailed report of the data management is provided on file.

Monitoring

The following step described in the protocol was considered not feasible and has not been done:

“To assess the quality of the coding we will review investigator comments and investigator texts as reported in the case report forms of approximately 200 patients experiencing thromboembolic events, 200 patients not experiencing thromboembolic events, and 200 patients who died. Once absolute numbers of thromboembolic events and deaths are available percentages of events to be reviewed will be calculated. Patients will be selected by random stratified by company. Which discrepancy rate will be accepted and which measures will be taken if the discrepancy rates is exceeded requires further discussion. In general, error rates during the process of data collection and data entry tend to be low. For example, error rates during data collection were estimated to be between 0.5% to 1.0% (Eisenstein 2005). In randomized controlled trials with blinding of study participants and study personnel, errors during data collection and data entry will be distributed randomly between groups and are unlikely to affect point estimates of difference between comparison groups. Computer simulations of analyses of moderate to large randomized controlled trials with real-time validation checks during data entry have found that error rates up to 10% had little effect (Mcentegart 1999). If and to which extend data submitted not by sponsoring companies but by independent investigators are monitored requires further discussion with the independent investigators.”

Assessment of risk of bias in included studies

The quality of the study data was assessed in the context of the individual patient data, study protocols, clinical study reports and available publications. For assessment of study quality and patient data level. Since all analyses were performed based on the intention-to-treat principle (analyzed in the allocated treatment arm); intention-to-treat was not assessed as a quality parameter.

The following quality components, which are part of the CONSORT statement, were assessed based on available study protocols, clinical study reports, publications or individual patient data:

1. Was treatment allocation sequence randomized? (assessed with study documents in duplicate, JB, SK)
2. Was treatment allocation concealed? (assessed with study documents in duplicate, JB, SK)
3. Were clinicians / care givers blinded (masked) to the allocated treatment? (assessed with study documents in duplicate, JB, SK)
4. Were patients blinded (masked) to the allocated treatment? (assessed with study documents in duplicate, JB, SK)
5. Were outcome assessors blinded (masked) to the allocated treatment? (assessed with study documents in duplicate, JB, SK)
6. What proportion of patients was excluded from the analysis and what was the ratio of exclusions between arms? This criterion has to be assessed for each endpoint separately (assessed with IPD data set)
7. Were the number and reason of patient withdrawals, dropouts and losses to follow-up in each group documented? (assessed with study documents, JB)

The quality assessment for the parameter 1 to 5 and 7 outlined above refer to the quality of the studies as reported in the available documents. These parameters therefore primarily reflect the reporting of these variables in the available documents. Data were extracted in duplicate and compared. Inconsistencies were discussed until consensus was reached. For any parameter that was “unclear” after assessment we did not contact the sponsors/ investigators for clarification. Because of time constraints we did not send questionnaires concerning the study design to the investigators to collect additional information as had been stated in the protocol. Specific coding rules used to assess the outlined study quality parameter are on file.

Measures of treatment effect

Organizational issues

Data management including data cleaning processes and derivation of new variables was done at the University of Cologne (CB). Main outcome variables (on study mortality and overall survival) were independently re-coded in duplicate at the Institute of Social and Preventive Medicine (ISPM) in Bern (KS). Main statistical analyses were done independently at the ISPM at the University of Bern (KS), Switzerland and the Institute of Medical Biometry and Medical Informatics (IMBI) at the University of Freiburg, Germany (GS). Any discrepancies were resolved in discussion during two meetings at the ISPM in Bern.

Results tables and graphs were provided to members of the Steering Committee and the Advisory Board and discussed during meetings or telephone conferences.

It was prespecified in the protocol to provide the following minimum set of tables and graphs (additional tables and graphs might be provided):

1. Baseline table: summary of each included trial for the variables (continuous variables are presented as means and medians with accompanying standard deviations; dichotomous variables are presented as proportions) (note: on file, not provided in this review).

2. Kaplan-Meier curves: standard Kaplan-Meier curves for each time-to-event outcome plus the number of patients under observation at specified time points for each trial (note: on file, not provided in this report). Reverse Kaplan-Meier curves: to assess time to censoring for each trial (note: on file, not provided in this review).
3. Event tables: for each time-to-event outcome a listing of the number of events, the number of patients included in the analysis, the patient-years of follow-up, and the mean observation time all separately for each trial (note: on file, not provided in this report).
4. Analyses tables: for each regression analysis a listing of hazard ratios of coefficients and interaction terms, accompanying 95% confidence intervals (derived from Wald test P values), and relevant P values from likelihood ratio tests (separately for each step of the respective analysis)
5. Forest plots: standard forests plots for each outcome separately
6. Funnel plots: standard funnel plots for each outcome separately

Dealing with missing data

Analysis set, missing data and losses to follow-up

- All analyses were performed based on the intention-to-treat principle: analyses included all randomized patients and patients were analyzed in the group they were allocated to, regardless of the treatment received or other protocol violations.
- In patients lost to follow up, time was censored at the date of last official study visit according to the respective study protocol.
- For patients censored on day one of randomization, 0.1 days was utilized as censoring time for technical reasons.

On study mortality

In the protocol we had defined on study mortality as time from randomization until 28 days after last planned ESA/placebo dose. In the statistical analysis plan we had specified two different methods for the generation of on study mortality:

- Administrative censoring: each patient will be censored at a preplanned point in time, i.e. planned duration of ESA study plus 28 days follow-up.
- Informative censoring: each patient will be censored at the last study visit during study period plus 28 days follow-up.

Ad 1: due to the complexity of the ESA studies this was not feasible. One difficulty was the different study designs of the ESA studies included. In about 32 studies there was a prespecified duration of ESA treatment. In 20 studies the duration of ESA administration was dependent on the duration of chemotherapy, i.e. ESA was given during the duration of chemotherapy. The duration of chemotherapy itself was variable, i.e. it was recommended to give additional 4 to 6 cycles of chemotherapy with a cycle length of 21 to 28 days. Therefore, it was not possible to set an administrative point of censoring based on the study information. In turn, using the duration of chemotherapy of the individual patient depends on the clinical course of the patient and can therefore not be regarded as “administrative”.

Ad 2: in the present study we analyzed the study data for on study mortality as provided by the companies and investigators, i.e. for each patient the companies and independent investigators

had submitted a date of “end of study”, (variable ENDSTUDDT_ in DISPOSIT table of data set), i.e. the last official study visit of the patient during active ESA study phase. In some of the studies, this “end of study date” included already a follow-up of 28 days, in other studies the date provided reflected the last visit and 28 days of follow had to be added. (Details of the programming of “on study mortality” on file, not provided in this review.)

Complete-case analyses

Main analyses were conducted based on complete-case analyses i.e. on patients with all data available for the relevant analysis. However, in the data sets received data were often not missing scattered across trials. In contrast, there were several trials which did not report specific variables for the entire study population. In the protocol we had stated the following: “The imputation of missing data (independent variables and continuous efficacy outcomes) using multiple imputation methods will be explored for sensitivity analyses.” Given the unbalanced pattern of missing data across studies we preferred not to impute any data.

Assessment of heterogeneity

Between-trial heterogeneity was visually examined in forest plots and assessed by calculating the I^2 statistic, which describes the percentage of total variation across studies that is due to heterogeneity rather than chance (Higgins 2002; Whitehead 2002). Standard tests of heterogeneity were also done. We examined small study effects in funnel plots of log hazard ratios or effect sizes against their standard error.

Assessment of reporting biases

Asymmetry of the funnel plot was assessed by the asymmetry coefficient (the difference in log hazard ratio or effect size per unit increase in standard error) (Sterne 2001) and tests for small study biases (Sterne 2001; Egger 2001; Egger 1997).

Data synthesis

Overview of statistical approaches

All analyses took into account the original randomization in each trial: no comparisons of patients from one trial with patients from another trial were made. Stratified Cox analyses were conducted in fixed-effects models. All other meta-analyses were conducted in both fixed- and random-effect models. The fixed-effect analysis was considered the primary analysis; the random-effects analysis was used to examine the robustness of the results.

We used pre-specified and exploratory variables; all variables were prespecified in the protocol for this analysis. The ‘main set’ of variables include variables that were defined for subset analyses in our first Cochrane Protocol in 2002 (Langensiepen 2002). We consider these variables to be truly pre-specified because they were documented *before* the first trials with detrimental effects on survival were published. All variables that were proposed later are influenced by the observations made when detrimental study results became available. These variables were considered as ‘exploratory’, see Appendix 2.

Two different approaches for individual patient data meta-analyses can be distinguished (Simmonds 2005). In the two-stage method the available IPD are analyzed separately for each trial and then combined using standard meta-analysis. The method is relatively

simple to apply in practice and well suited to assess between trial heterogeneity caused by study level characteristics. It is, however, less suitable to identify prognostic factors and interactions of patient level characteristics. A meta-analysis of IPD can also be seen as a multilevel model, with essentially two levels, the first level being the patients and the second level being the studies. This framework therefore allows estimating effects of interest in relation to both study-level covariates and patient-level covariates.

Analysis to address objective 1: effects of ESAs

Meta-analyses were based on a Cox regression analysis stratified by trial with treatment as the only factor in the model. This approach is a fixed-effect model which allows for different baseline hazard functions in each trial (Smith 2007). Log rank estimates were calculated for each study and meta-analyzed based on the fixed and the random-effects models. We also calculated (log)-hazard ratios for each trial separately using standard Cox regression analysis, which were then combined using fixed-effects and the DerSimonian-Laird random-effects model (DerSimonian 1986). The assumption of proportional hazards was examined on the basis of Schoenfeld residuals and graphically using log-log plots for each trial included.

Baseline imbalances

We assessed whether baseline imbalances could explain any effects seen on time-to-event outcomes. Bivariate Cox regression analysis stratified by trial was used. The variables that were considered as independent variables besides treatment are listed in Appendix 2. All variables with a corresponding P value of less than 0.10 were included in a multivariate Cox regression analysis stratified by trial. The following procedure was stated in the protocol: “Model selection was based on a standard stepwise selection procedure with 5% inclusion/exclusion criteria based on the likelihood ratio test.” Since we had many missing data and the missing data were not distributed evenly across trials (data were often missing for entire studies), the selection for variables was based on P value of the Likelihood Ratio (LR) test as stated above and number of cases reported per variable. We also planned to explore the possibility to implement a Cox regression model stratified by trial with random treatment effects (Smith 2005). However, since the heterogeneity between trials was low and the results of the log-rank based meta-analyses for both fixed and random-effects models were model identical, this was not considered a priority.

Methodological characteristics of trials

The following method was stated in the protocol: “Univariable fixed-effect meta-regression based on the (log)-hazard ratios of effect sizes of individual trials were used to examine whether treatment effects vary by trial level characteristics. The variables that will be considered as independent variables are listed in Appendix 2. All variables with a corresponding P value of less than 0.10 will be included in a multivariate fixed-effect meta-regression analysis. For the survival analysis only variables 1 to 3 and 5 to 8 outlined in Appendix 2 will be included in the model. Random-effects meta-regression will be used to explore the robustness of the results.” Instead the study level parameters were assessed in the Cox model by using interaction terms. Meta-regression analyses were used for exploration of effect modifiers at study level (exploratory analysis).

Continuous independent variables

The following step was planned but considered to be not feasible: “Non-linear effects of continuous variables were examined by comparing linear models with models with quadratic terms using the Akaike Information Criterion (Akaike 1974). Alternative methods of analyzing continuous variables will be explored (Boucher 1998; Royston 1999).” The following procedure was done: continuous variables were included in the multivariate models based on categories that had been outlined in the protocol for this analysis.

Hematological response

Analysis of hematological response and other time dependent explanatory variables was postponed.

Assessment of eligible studies not included in the present analysis

To assess the impact of eligible studies with no available individual patient data, these studies were included in the analyses based on the aggregated results reported in the literature or provided by the investigators, see 'Results' section.

Numbers needed to treat

We calculated numbers needed to treat for one additional harmful outcome (NNTH) (Altman 1999; Altman 1998).

Sample size considerations

The sample size was determined by the number and size of trials for which individual patient data were available as well as the event rates in these trials. We had previously updated the literature based Cochrane Review (including studies up to end of June 2007) and identified 53 studies including 12353 patients that did fulfill the eligibility criteria outlined above. These studies reported approximately 4400 deaths from all causes. These numbers were preliminary estimates. Based on these estimates we assumed that the combined data set was to provide sufficient statistical power to detect clinically relevant adverse effects of ESA treatment, although power was expected to be insufficient to exclude small effects. Also, power was expected to be more limited for analyses of interactions. For number of studies, patients and events reported in the present analysis see 'Results' section.

Limitations

Multiple testing

This is an exploratory study and several hypotheses tests were performed. No adjustments for multiple testing were made and no higher confidence levels for confidence intervals were applied. The multiplicity of analyses, however, has to be considered when interpreting the result.

Comparison of different drug formulations

No separate analysis by ESAs (epoetin alpha, epoetin beta and darbepoetin alpha) nor any comparisons between the different ESAs was made upon specific request of the companies providing data for this study.

Organizational structure

All study centers that conducted ESA studies were invited to join the collaborative group and submit their individual patient data. Data

were held securely and treated confidentially. Analyses, results and their interpretation were discussed with the collaborators.

Secretariat

The secretariat for this project was located at the Editorial Base of the Cochrane Haematological Malignancies Group in Cologne, Germany. The secretariat coordinated the project.

Statistical Analyses and Data Management

All data were anonymized and sent encrypted to the data center at the University of Cologne. Statistical analyses were done independently at the Institute of Social and Preventive Medicine (ISPM) at the University of Bern, Switzerland and the Institute of Medical Biometry and Medical Informatics (IMBI) at the University of Freiburg, Germany.

Steering Committee

The steering committee for this project consists of an international group of experts for hematology, oncology, radiotherapy, clinical epidemiology/biostatistics and a consumer representative. The steering committee gave advice on strategic issues and analyses. Final decisions concerning inclusion and exclusion of studies, statistical analyses and interpretation of findings were made by the Steering Committee. The tasks of the Steering Committee are documented in the Steering Committee Charter (on file, not provided in this review).

Advisory Board

Trialists and pharmaceutical companies who provided data for the analysis joined the Advisory Board. All data analyses were presented to the Advisory Board. The Advisory Board could give advice to the secretariat and the steering committee, but had no decision-making authority. The tasks of the Advisory Board are documented in the Advisory Board Charter (on file, not provided in this review).

Protocol amendments

Protocol changes were avoided whenever possible. If nonetheless changes became necessary they were documented in an amendment. Any substantial change or addition to this protocol required a written protocol amendment that had to be approved by the Steering Committee and the Advisory Board. There was not substantial change to the protocol.

Subgroup analysis and investigation of heterogeneity

Analysis to address objective 2: analysis of effect modification (treatment by covariate interaction)

The focus of this analysis was on first order multiplicative interactions of independent variables with allocated treatment.

The variables that were considered as independent variables are listed in [Appendix 2](#). Bivariate Cox regression analyses with factor and treatment allocation stratified by trial and including the respective factor-treatment interaction term (treatment by independent variable) were used. Models with and without the respective interaction term were compared using the likelihood ratio test. The possibility to implement a model with multiple interaction terms was reported in the protocol but not explored in the current analysis. Methodological characteristics of the studies (e.g. concealment of allocation, placebo controlled) were assessed using interaction terms. In addition, the following exploratory analyses were done: Meta-regression analyses were conducted for study level variables with statistically significant effect modifications in the bivariate analyses. Meta-regression was based on unadjusted and adjusted hazard ratios of the individual studies. Differences for subgroups generated with the meta-regression analyses were tested with the Wald test.

Sensitivity analysis

Additional sensitivity analyses were performed to further check the robustness of the results.

RESULTS

Description of studies

Results of the search

A total of **5546 hits** (including duplicates caused by an overlap of the three data base searches outlined above) were identified from the literature databases. Out of the 5546 references identified 447 full text publications were retrieved for assessment. Electronic searches of ongoing studies data bases retrieved 575 hits.

Baseline characteristics overall

A total of 13933 patients were evaluated in the present analysis. At randomization the median age was 60.6 years in the ESA and 59.8 years in the control group. Hb at baseline was on average 10.6 g/dL (IQR 9.6 to 12.1 g/dL) in the ES and 10.8 g/dL (IQR 9.6 to 12.5 g/dL) in the control group. 18.3% of patients in the ESA and 15.9% of patients in the control group were diagnosed with a hematological malignancy, whereas 76.6% of ESA patients and 78.5% of control patients were diagnosed with a solid tumor. 30.9% of the entire patient population was diagnosed with breast cancer and 22.1% with lung cancer, including SCLC and NSCLC. 63.1% of patients included in the current analysis were female. For details of the patient population see [Figure 1](#), [Figure 2](#) and [Figure 3](#).

Figure 1. Baseline characteristics, a)

Table: 1 Baseline characteristics

Total number of patients: 13933
Patients in ESA arm: 7634
Patients in Control arm: 6299

ESA arm

Variable	N	mean	sd	min	p25	p50	p75	max
Hgb_b	7382	10.8291	1.928811	3.11	9.6	10.6	12.1	17.3
Age_b	7628	59.66763	12.93621	5.557837	51.51129	60.62286	69.19781	93.38261
Hct_b	6141	32.51435	5.426188	10.8	29	32	36	52
Serepo_b	3263	108.1099	322.0879	0	23.7	43.704	93.029	9193.825
BMI	6119	.0026861	.0128262	.0003489	.0021778	.0024419	.0027677	.9999
Cancertime*	2496	17.25382	34.31808	0	.6885246	2.459016	17.19672	342.6885

*time from cancer diagnosis to date of randomization

Control arm

Variable	N	mean	sd	min	p25	p50	p75	max
Hgb_b	6025	11.00551	1.969058	3.3	9.6	10.8	12.5	18.9
Age_b	6293	58.88413	12.87002	5.221081	50.83641	59.81109	68.11773	92.37782
Hct_b	4895	32.89641	5.604166	13	29	32.3	37	61
Serepo_b	2388	103.3455	277.5673	0	24.1475	43.6	85.2235	5988
BMI	5327	.0026987	.0136761	0	.0021718	.0024405	.0027718	.9999
Cancertime*	2090	15.32991	33.04531	-9.737705	.6557377	1.639344	13.27869	327.5082

*time from cancer diagnosis to date of randomization

	ESA	Control
Hb baseline categories [g/dl]		
] 0 - 8]	448 (5.9%)	343 (5.4%)
] 8 - 10]	2222 (29.1%)	1708 (27.1%)
]10 - 12]	2851 (37.3%)	2153 (34.2%)
]12 - 14]	1433 (18.8%)	1410 (22.4%)
> 14	428 (5.6%)	411 (6.5%)
Missing	252 (3.3%)	274 (4.3%)
Hb baseline categories [g/dl]		
] 0 - 8]	448 (5.9%)	343 (5.4%)
] 8 - 9]	742 (9.7%)	577 (9.2%)
] 9 - 10]	1480 (19.4%)	1131 (18.0%)
]10 - 11]	1699 (22.3%)	1228 (19.5%)
]11 - 12]	1152 (15.1%)	925 (14.7%)
]12 - 13]	873 (11.4%)	866 (13.7%)
]13 - 14]	560 (7.3%)	544 (8.6%)
> 14	428 (5.6%)	411 (6.5%)
Missing	252 (3.3%)	274 (4.3%)
Tumor type category		
Hematological malignancies	1400 (18.3%)	1003 (15.9%)
Solid tumors	5848 (76.6%)	4967 (78.5%)
Other	369 (4.8%)	324 (5.1%)
Missing	17 (0.2%)	25 (0.4%)
Tumor type many categories		
Hematological malignancies	1400 (18.3%)	1003 (15.9%)
Breast cancer	2245 (29.4%)	2057 (32.7%)
Head and neck cancer	443 (5.8%)	425 (6.8%)
Lung cancer (NSCLC & SCLC)	1618 (21.2%)	1458 (23.1%)
Gastrointestinal cancer	434 (5.7%)	274 (4.3%)
Gynecological cancer	842 (11.0%)	557 (8.8%)
Genitourinary cancer	266 (3.5%)	176 (2.8%)

Figure 1. (Continued)

Gynecological cancer	842 (11.0%)	557 (8.8%)
Genitourinary cancer	266 (3.5%)	176 (2.8%)
Other cancer	369 (4.8%)	324 (5.1%)
Missing	17 (0.2%)	25 (0.4%)

Figure 2. Baseline characteristics b)

Sex		
Male	2854 (37.4%)	2282 (36.2%)
Female	4780 (62.6%)	4017 (63.8%)
Age at randomization [years]		
<18	55 (0.7%)	68 (1.1%)
[18 - 35[	191 (2.5%)	155 (2.5%)
[35 - 45[	745 (9.8%)	598 (9.5%)
[45 - 55[	1614 (21.1%)	1396 (22.2%)
[55 - 65[	2237 (29.3%)	1956 (31.1%)
[65 - 75[	1970 (25.8%)	1547 (24.6%)
=> 75	816 (10.7%)	573 (9.1%)
Missing	6 (0.1%)	6 (0.1%)
Hct baseline categories [%]		
] 0 - 23.5]	210 (2.8%)	180 (2.9%)
]23.5 - 29.4]	1567 (20.5%)	1221 (19.4%)
]29.4 - 35.3]	2692 (35.3%)	1923 (30.5%)
]35.3 - 41.2]	1258 (16.5%)	1200 (19.1%)
>41.2	414 (5.4%)	371 (5.9%)
Missing	1493 (19.6%)	1404 (22.3%)
Baseline serum epo (mu/ml)		
<25	876 (11.5%)	621 (9.9%)
[25 - 100[	1643 (21.5%)	1265 (20.1%)
[100 - 200[	451 (5.9%)	289 (4.6%)
[200 - 500[	190 (2.5%)	135 (2.1%)
>= 500	103 (1.3%)	78 (1.2%)
Missing	4371 (57.3%)	3911 (62.1%)
Baseline ECOG performance status		
ECOG 0	1808 (23.7%)	1584 (25.1%)
ECOG 1	2779 (36.4%)	2121 (33.7%)
ECOG 2	933 (12.2%)	745 (11.8%)
ECOG 3	77 (1.0%)	62 (1.0%)
ECOG 4	2 (0.0%)	1 (0.0%)
Missing	2035 (26.7%)	1786 (28.4%)
Baseline ECOG performance status category		
ECOG 0,1 or 2	5578 (73.1%)	4505 (71.5%)
ECOG 3 or 4	79 (1.0%)	63 (1.0%)
Missing	1977 (25.9%)	1731 (27.5%)
Body mass index category [kg/m2]		
]0 - 19]	424 (5.6%)	441 (7.0%)
]19 - 25]	2964 (38.8%)	2523 (40.1%)
]25 - 30]	1864 (24.4%)	1579 (25.1%)
> 30	867 (11.4%)	783 (12.4%)
missing	1515 (19.8%)	973 (15.4%)
Documented history of thromboembolic event?		
Yes	318 (4.2%)	243 (3.9%)
No	5044 (66.1%)	4015 (63.7%)
Not reported	1106 (14.5%)	1073 (17.0%)
Missing	1166 (15.3%)	968 (15.4%)
Documented history of cardiovascular event?		
Yes	2002 (26.2%)	1591 (25.3%)
No	3700 (48.5%)	3029 (48.1%)
Not reported	766 (10.0%)	711 (11.3%)
Missing	1166 (15.3%)	968 (15.4%)
Documented history of hypertension?		
Yes	1219 (16.0%)	874 (13.9%)
No	4143 (54.3%)	3384 (53.7%)
Not reported	1106 (14.5%)	1073 (17.0%)

Figure 2. (Continued)

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No	4143 (54.3%)	3384 (53.7%)
Not reported	1106 (14.5%)	1073 (17.0%)
Missing	1166 (15.3%)	968 (15.4%)

Figure 3. Baseline characteristics c)

Documented history of diabetes mellitus?		
Yes	372 (4.9%)	337 (5.4%)
No	3927 (51.4%)	3389 (53.8%)
Not reported	2169 (28.4%)	1605 (25.5%)
Missing	1166 (15.3%)	968 (15.4%)
Region		
Northern America	2004 (26.3%)	1565 (24.8%)
Southern Europe	541 (7.1%)	441 (7.0%)
Australia and New Zealand	216 (2.8%)	126 (2.0%)
Eastern Europe	1030 (13.5%)	925 (14.7%)
Northern Europe	1240 (16.2%)	1013 (16.1%)
Western Europe	2249 (29.5%)	1956 (31.1%)
Other	123 (1.6%)	103 (1.6%)
Missing	231 (3.0%)	170 (2.7%)
Region category		
Northern America	2004 (26.3%)	1565 (24.8%)
Northern, Southern, Western Europe	4030 (52.8%)	3410 (54.1%)
Eastern Europe	1030 (13.5%)	925 (14.7%)
Australia and New Zealand	216 (2.8%)	126 (2.0%)
Other	123 (1.6%)	103 (1.6%)
Missing	231 (3.0%)	170 (2.7%)
Chemotherapy given before esa study?		
Yes	3111 (40.8%)	2262 (35.9%)
No	2558 (33.5%)	2301 (36.5%)
Not reported	799 (10.5%)	768 (12.2%)
Missing	1166 (15.3%)	968 (15.4%)
Radiotherapy given before esa study?		
Yes	487 (6.4%)	390 (6.2%)
No	4618 (60.5%)	3693 (58.6%)
Not reported	1363 (17.9%)	1248 (19.8%)
Missing	1166 (15.3%)	968 (15.4%)
Stage		
Metastatic/advanced	4482 (58.7%)	3631 (57.6%)
Not metastatic/not advanced	2116 (27.7%)	1923 (30.5%)
Unclear, missing, not reported	1036 (13.6%)	745 (11.8%)

Included studies
Eligible studies

A total of 63 studies were eligible for inclusion into this analysis. For 10 of the 63 studies we could not retrieve individual patient data for the present analysis (Blohmer 2003; Overgaard 2007; Bamias 2003; Watanabe 2006; Antonadou 2001; Janinis 2003; Iconomou 2003;

Mystakidou 2005; Zajda 2007; Cascinu 1994). For six (Antonadou 2001; Mystakidou 2005; Cascinu 1994; Blohmer 2003; Overgaard 2007; Bamias 2003) of the ten studies aggregated survival data were reported in the literature or provided by the investigator and included in a sensitivity analysis to assess the impact of the missing studies on overall survival. In the other four studies survival data

were not reported in the literature ([Watanabe 2006](#); [Janinis 2003](#); [Iconomou 2003](#); [Zajda 2007](#)).

Included studies

For a total of 53 eligible studies we retrieved individual patient data, for list of included studies see 'Characteristics of studies' table. Forty-eight studies were provided by one of the three companies Johnson & Johnson, Roche and Amgen. Three independent investigators provided individual patient data by the means of the company ([Moebus 2007](#); [Untch 2008](#), [Machtay 2007](#)). Two independent investigators provided the data in the requested format directly to the collaborative group ([Ray-Coquard 2006](#); [Thomas 2008](#)).

Included and excluded patients

We received the data sets for 56 studies including 14393 patients. From the data set the following exclusions were made:

Total received: n=14393 patients, 56 studies

Exclusion of three studies including 187 patients, which did not meet the inclusion criteria ([MF4266](#), [MF4252](#) ([Rau 1998](#)), [MF4253](#) ([Kettelhack 1998](#)).

n=14206 patients, 53 studies

Exclusion of patients without allocated study arm

[MF4467](#) ([Osterborg 2002](#)) (n=162)

[MF4250](#) ([Osterborg 1996](#)) (n=1)

[MF4421](#) ([Boogaerts 2003](#)) (n=1)

n=14042 patients, 53 studies

Exclusion of ineligible study stratum: study PR99-11-034/044 ([Razzouk 2006](#)), children with acute lymphocytic leukemia, Non-Hodgkin lymphoma (stratum 1, n=98), Hodgkin disease and solid tumors (stratum 2), stratum 1 was excluded.

n=13944 patients, 53 studies

For studies where the date of randomization was missing for all patients, the date of randomization was replaced with the date of first study drug as provided by the company (variable FSTTXDT from the data table DISPOSIT): study [MF4421](#) ([Boogaerts 2003](#)).

For studies where only single patients had no date of randomization the patients were excluded from the analysis.

[EPO-INT-3](#) (n=1)

[DE20010033](#) ([Untch 2008](#)) (n=4)

[MF4313](#) ([Cazzola 1995](#)) (n=3)

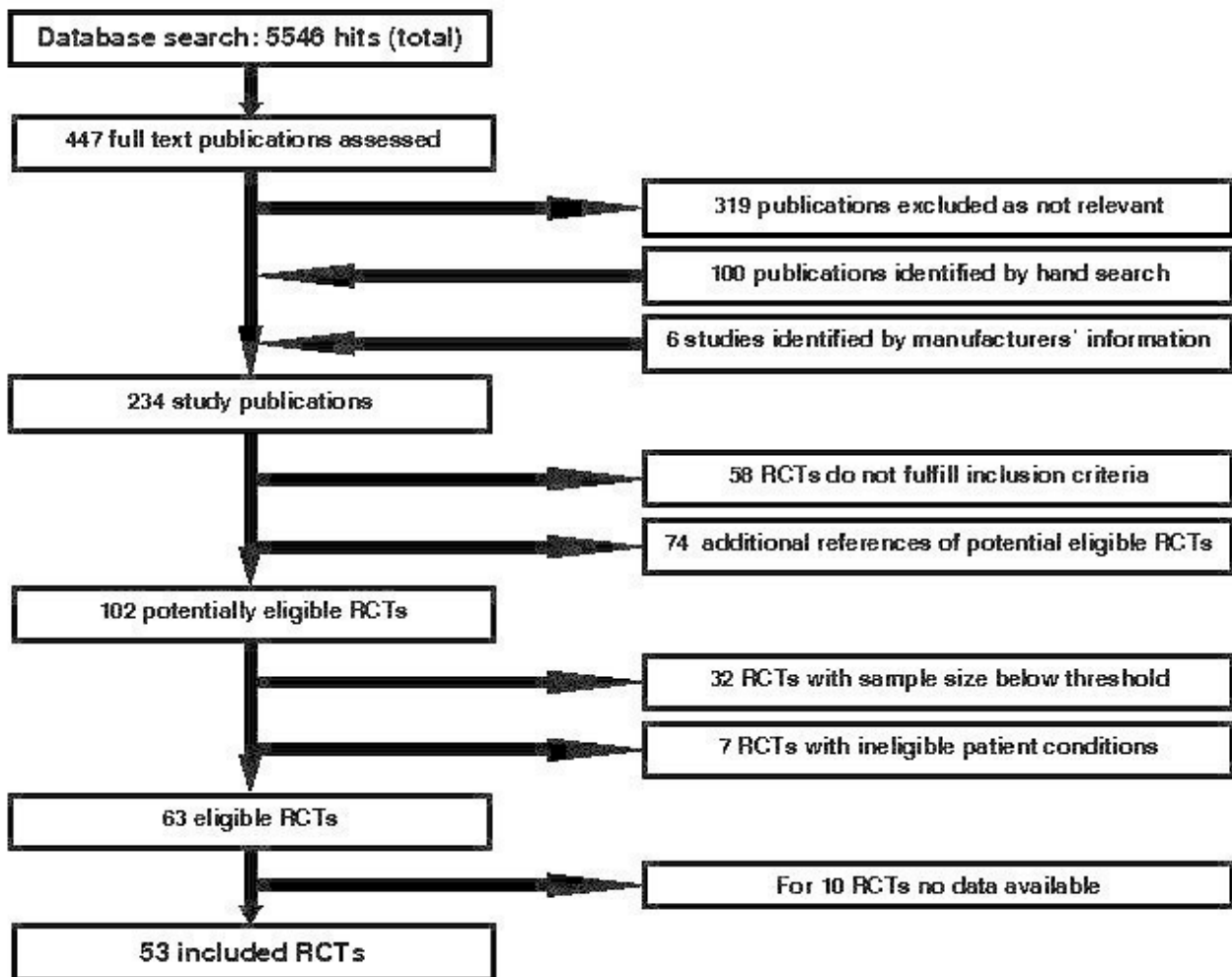
N=13936 patients, 53 studies

If both date of randomization and date of first study drug were missing in study [MF4421](#) ([Boogaerts 2003](#)) (see above) these patients were excluded (n=3).

Total included: N=13933 patients, 53 studies

For identification of eligible trials see [Figure 4](#).

Figure 4. Identification of eligible trials



Characteristics of included studies

Cancer entities

Both patients with hematological malignancies and solid cancers were included in the evaluated studies. Some studies were restricted to single disease entities whereas other studies included various tumor types. Some studies were restricted to patients with identical stages of disease, whereas others included both early and advanced stages.

In detail, the following cancers were explored:

Breast cancer

Seven studies evaluated patients with breast cancer only. Of these, two studies included only patients with metastatic disease (Aapro 2008; Leyland-Jones 2003). Two studies included only patients with non-metastatic disease (Moebus 2007; Untch 2008). Three studies included patients with stages I to IV (Chang 2005; O'Shaughnessy 2005; Pronzato 2002).

Lung cancer

Nine studies evaluated patients with lung cancer only. Of these, five studies included patients with small cell lung cancer (SCLC)

only. Goss 2005 included patients with limited disease SCLC. Pirker 2008 and EPO-GER-20 included patients with extensive disease SCLC. Grote 2005 included both patients with limited and extensive SCLC. Thatcher 1999 included SCLC without providing details on disease stage. Three studies included patients with non-small cell lung cancer (NSCLC) only. Debus 2006 included NSCLC patients with inoperable stage III, Wright 2007 and Milroy 2003 included advanced stage NSCLC patients. Vansteenkiste 2002 included patients with limited and advanced stage SCLC and NSCLC.

Head and neck cancer

Three studies included patients with head and neck cancer only, including stages I-IV (EPO-GBR-7) stages III and IV (Henke 2003) or non metastatic stages I-IV only (Machtay 2007). Patients in these studies received radiotherapy.

Cervical cancer

Two studies included patients with cervical cancer only, both studies were restricted to patients in stages IIB to IVA (Thomas 2008; Strauss 2008). Patients in these studies received radiochemotherapy.

Ovarian cancer

Three studies included patients with ovarian cancer only, of these, two studies included patients with stages I-IV (EPO-INT-1; Wilkinson 2006). The third study included patients in stage II-IV (Ten Bokkel Huinink 1998).

Gastric or rectal cancer

One study was restricted to patients with gastric and rectal cancer (stages I-III) (Vadhan-Raj 2004). Patients received radiochemotherapy.

Multiple myeloma

Two studies were restricted to patients with multiple myeloma (Dammacco 2001; OBE/EPO-INT-03).

Chronic lymphocytic leukemia

Two studies included chronic lymphocytic leukemia (CLL) patients only (CC2574-P-174; Rose 1994). Patients received chemotherapy or corticosteroids only

Mixed cancer populations

The other 24 studies included mixed cancer populations.

- Various hematological malignancies

Four studies were restricted to patients with different hematological malignancies (Hedenus 2003; Osterborg 1996; Osterborg 2002; Cazzola 1995).

- Various solid tumors

Fixe studies were restricted to patients with different solid tumors (Kotasek 2003; Kotasek 2002; Oberhoff 1998; Savonije 2005; Huddart 2002)

- Both solid tumors and hematological malignancies

Fifteen studies included patients with a wide range of different tumor entities, including both patients with solid cancer and hematological malignancies (Charu 2007; Ray-Coquard 2006; Littlewood 2001; EPO-INT-3; Abels 1993; Henry 1995; Case 1993; Witzig 2005; Razzouk 2006; Quirt 1996; Gordon 2006; Taylor 2005; Smith 2008; Thomas 2002; Boogaerts 2003).

Cancer treatment

In thirty eight studies patients received chemotherapy during ESA treatment. In two of these studies (Moebus 2007; Untch 2008) the chemotherapy was followed by radiotherapy. However, in both studies ESA was given only during the duration of chemotherapy and the studies were therefore categorized in the chemotherapy population. In two studies (CC2574-P-174; Rose 1994), both studies included CLL patients only, 40% (information taken from clinical study report (CSR) (CC2574-P-174) and 41% (information taken from CSR (Rose 1994)) of the patients received no chemotherapy during ESA treatment. These studies were categorized as “mixed”.

Note: the investigator of these two studies (CC2574-P-174; Rose 1994) had recommended to evaluate the studies in the “chemotherapy” population. However, based on our predefined criteria that 70% of a study population had to receive a planned treatment to be categorized within that treatment group we

decided not to include these two studies in the chemotherapy population.

In three of the included studies patients received radiotherapy only, in all of these three studies only patients with head and neck cancer were included (EPO-GBR-7; Henke 2003; Machtay 2007). In another five studies patients were receiving a combined chemo radiotherapy, defined as concomitant use of chemotherapy and radiotherapy. These studies included patients with cervical cancer (Strauss 2008; Thomas 2008), SCLC (Goss 2005), NSCLC (Debus 2006) and gastric and rectal cancers (Vadhan-Raj 2004), none of these studies included patients with head and neck cancer.

In the study EPO-GER-22 (Debus 2006) chemotherapy was followed by radiotherapy. However, since the planned interval between chemotherapy and radiotherapy was short it was decided to classify this study as “radiochemotherapy” study. These five studies were evaluated together with the three radiotherapy studies in the radio(chemo)therapy population. In sensitivity analyses we explored whether regrouping of these studies would influence the results (see Appendix 3).

In five of the included studies patients did not receive concomitant myelosuppressive chemotherapy and/or radiotherapy (Charu 2007; Smith 2008; Gordon 2006; Wright 2007; Abels 1993).

Apart from the two studies described above (Rose 1994; CC2574-P-174) no other study was categorized as “mixed”, i.e. in no other study less than 70% but more than 30% of the patients were receiving either chemotherapy or radiotherapy or no anticancer treatment.

Only seven of the 48 studies, where a myelosuppressive anticancer treatment was given, had a prespecified chemotherapy or radiotherapy protocol that targeted a homogenous cancer population (Untch 2008; Witzig 2005; Debus 2006; Strauss 2008; Thomas 2008; Moebus 2007; Machtay 2007). For sensitivity analyses see Appendix 3.

ESA dosages and schedules

The frequency of ESA application ranged from seven times per week for the short lasting ESA preparations to once every four weeks for the long lasting ESA preparations. Most often ESAs were applied three times per week (26 studies) or once per week (15 studies). In the ELYPSE 4 study (Ray-Coquard 2006) the frequency was dependent on body weight of the patients, e.g. if body weight < 45 kg patients received 2 x 10000 IU per week, if body weight 45 to 89 kg 3 x 10000 IU per week and for patients with body weight > 90 kg the dose was 4 x 10000 IU per week. In the study 20010145 (Pirker 2008) the frequency changed over time, i.e. 1 x 300 µg once per week sc weeks 1-4 then 300 µg three times per week starting week 5 onwards.

In all but one study (Razzouk 2006) ESA was given subcutaneously. In the study by (Razzouk 2006) ESA was given intravenously.

In 19 studies ESAs were given in a fixed dose, i.e. independent from body weight. In 27 studies the individual ESA dosage was calculated based on the patient’s body weight. In six studies (Ray-Coquard 2006; EPO-GBR-7; Milroy 2003; Wilkinson 2006; Pronzato 2002; Thomas 2002) the dose was adjusted, i.e. there were different fix dosages dependent on the weight or the age of the patients. For example, in the study EPO-INT-50 (Thomas 2002) patients with

body weight < 45 kg received 3 x 5000 IU per week and patients with body weight > 45 kg received 3 x 10000 IU ESA per week. In the study MF4250 the ESA dose was titrated ([Osterborg 1996](#)).

The planned weekly Epoetin (alpha or beta) dose ranged from 21000 IU up to 63000 IU. Studies were classified based on an assumed average dose per study and not per patient. In detail: for studies where patients were receiving weight based Epoetin dosages the overall dose for the entire study was calculated based on a assumed patient weight of 70 kg. For the present analysis the doses were not calculated for the individual patient.

The planned weekly Darbepoetin dose ranged from 100 microgram up to 157.5 microgram. For patients receiving weight based Darbepoetin dosages the dose was calculated based on an assumed patient weight of 70 kg for the entire study. For the present analysis the doses were not calculated for the individual patient.

In 19 studies patients were planned to receive on average less than 40000 IU Epoetin or less than 100 micro grams Darbepoetin per week. In 12 studies patients were planned to receive 40000 IU Epoetin or 100 micro grams Darbepoetin per week. In eight studies patients were planned to receive on average more than 40000 IU Epoetin or more than 100 micrograms Darbepoetin per week. In 14 studies the planned ESA dosages depended on various factors and we could therefore not calculate a single ESA dosage per study.

The planned duration of ESA administration ranged from eight weeks up to 52 weeks. In 20 studies the duration of ESA administration was dependent on the duration of chemotherapy, i.e. ESA was given during the duration of chemotherapy. In one study [Smith 2008](#) patients in the active study received ESA for 16 weeks and could continue ESA treatment for additional 16 weeks after the end of study period. Patients in the control group did not receive ESA. For the present analysis this study was categorized as “ESA treatment longer than 17 weeks”.

Cross-over

In twelve studies patients in both the control arm and the active arm were allowed to receive ESAs after a defined study period ([Charu 2007](#); [Kotasek 2003](#); [Kotasek 2002](#); [CC2574-P-174](#); [Dammacco 2001](#); [EPO-INT-3](#); [Leyland-Jones 2003](#); [Abels 1993](#); [Case 1993](#); [Henry 1995](#); [Rose 1994](#); [Oberhoff 1998](#)). Our aim was to include only events and time under observation during this defined treatment period in the analysis. Therefore, these studies were evaluated for both the on study mortality and overall survival analysis restricted to the active treatment phase during which control patients did not receive ESAs.

Cross-over studies were included in the analysis as follows:

Three studies provided by Amgen:

- [Charu 2007](#), study 53081: last actual ESA dose plus 14 days (truncated before 1. drug injection during open label phase, as provided by the investigator)
- [Kotasek 2003](#), study 35466: last actual ESA dose days plus 21 days (truncated before 1. drug injection during open label phase, as provided by the investigator)
- [Kotasek 2002](#), study 26117: last actual ESA dose days plus 28 days (truncated before 1. drug injection during open label phase, as provided by the investigator)

Eight studies provided by Johnson & Johnson (studies [Dammacco 2001](#), [Leyland-Jones 2003](#), [Case 1993](#), [EPO-INT-3](#), [CC2574-P-174](#), [Henry 1995](#), [Rose 1994](#), [Abels 1993](#)).

- All studies were truncated at termination visit plus 28 days in both arms

One study provided by Roche ([Oberhoff 1998](#)):

- The study was truncated as provided by the company; i.e. for the control arm we received the data from the controlled study phase only, in the ESA arm the follow-up was apparently longer.

For the study EPO-INT-76 ([Leyland-Jones 2003](#)) it was discussed whether there was a relevant “cross-over” after the end of the active study phase since the study was stopped prematurely. However, in the CSR it is reported that 641 patients continued in the open label phase. Of those 413 did not receive ESA and 228 (placebo 134, ESA 94) patients were treated with ESA in the open label phase. The median exposure to ESA in this population was 4.14 weeks (range 0.1; 50.1). The survival evaluation for the study EPO-INT-76 was therefore restricted to the active study phase. For a post hoc analysis percentages of patients receiving ESAs after the controlled phase were recorded from either the clinical study report or provided by the investigator and an exploratory survival analysis was conducted, see [Appendix 4](#).

Hb ceiling

Hb ceiling was defined as Hb value when ESA had to be stopped. In none of the included studies the ceiling was 12 g/dL or below. In six studies the ceiling was 13 g/dL, in 20 studies 14 g/dL, in nine studies 15 g/dL and in two studies the ceiling was 16 g/dL. In nine studies the ceilings for men and women were different. In seven of these studies the ceiling was 15 g/dL for men and 14 g/dL for women, in two of the studies ([EPO-INT-3](#), [Machtay 2007](#)) the ceiling was 16 g/dL for men and 14 g/dL for women. Two studies used different ceilings for different patients groups (MF4313 for Multiple myeloma (MM) Hb 13 g/dL, for NHL Hb 15 g/dL) ([Cazzola 1995](#)) or different age groups (PR99-11-034/044 for children aged > 12 Hb >= 15 g/dL, for children aged ≤ 12 Hb >= 14 g/dL) ([Razzouk 2006](#)). In four studies: J89-040 ([Rose 1994](#)), [CC2574-P-174](#), I88-036, 87-018, 87-019 ([Henry 1995](#)), I88-037, 87-016, 87-017 ([Case 1993](#)) the ceiling was defined based on hematocrit units: ceiling hematocrit 38% in the studies I88-036, 87-018, 87-019 ([Henry 1995](#)), I88-037, 87-016, 87-017 ([Case 1993](#)); in the studies J89-040 ([Rose 1994](#)) and [CC2574-P-174](#) there was no explicit hematocrit ceiling reported but the Hct was to be maintained between 38% and 40%. Both studies followed similar/identical study protocols. After discussion with the investigator of these studies Hct 40% was used as ceiling for these studies. To convert the Hct based ceilings into Hb based ceilings the Hct values were multiplied with 0.34. In one study the ceiling was not reported ([Abels 1993](#)).

For two studies the ceiling was changed during the study. For EPO-GER-22 ([Debus 2006](#)) the initial Hb ceiling was 14 g/dL, after 17.11.2003 the ceiling was 13 g/dL. For EPO-CAN-15 ([Goss 2005](#)) the initial ceiling was 16 g/dL, after 1.12.2002 the ceiling was 14 g/dL. For the present analysis we computed the ceiling for each individual patient based on the ceiling that was valid on the day the patient was randomized.

Since several studies had used different ceilings for different patient populations, e.g. depending on sex, age and underlying disease, or

changed the ceiling over time, ceiling categories for the analyses were constructed based on the patient level information.

Iron supplementation

In seven studies patients received a fixed iron supplementation. In 26 studies iron was given as needed following a specific protocol and in 19 studies iron was given as needed by discretion of physician or institutional policy. In none of the studies it was explicitly reported that iron should not be used. In one study (Grote 2005) iron supplementation was coded as “other”. In this study it was reported in the clinical study report how many patients received oral iron during study, but there was no statement if and how patients and physicians were advised to use iron. For the present analysis the study was evaluated in the category “iron given as needed by discretion of physician or institutional policy”.

In seven studies iron was given only in the ESA arm (Machtay 2007; Untch 2008; Moebus 2007; Debus 2006; Savonije 2005) or the policies for iron monitoring and supplementation were different in ESA and control arm (OBE/EPO-INT-03; EPO-GER-20). In the Savonije et al 2005 (Savonije 2005) study ESA patients had to receive iron mandatory by protocol, it is unclear from the clinical study report whether patients in the control arm received iron as well. In one unpublished study (OBE/EPO-INT-03) the iron status in the ESA arm was to be monitored and if needed supplemented. In the another unpublished study (EPO-GER-20) patients in the ESA arm received iron fixed and patients in the control arm received iron only if needed.

Excluded studies

see 'Characteristics of excluded studies' table

Risk of bias in included studies

Allocation

Study level parameter

Randomization and concealment of allocation

Sixteen studies were judged independently by two reviewers (JB, SK) to have reported an adequate randomization procedure, for 37 studies the method reported was judged to be unclear based on the available documents, i.e. clinical study reports, study protocols and publications if available. Thirty-six studies were judged to have reported adequate allocation concealment, for 17 studies the method reported was judged to be unclear based on the available documents. For ten of the 53 included studies both randomization and concealment of allocation was judged to be adequate. For another eleven studies both method of randomization and concealment of allocation were judged to be unclear. For 26 studies the method of allocation was judged to be adequate but the method of randomization was unclear. For six studies the method of randomization was judged to be adequate but the method of allocation concealment was unclear.

Blinding

Placebo control

28 studies were placebo controlled and were reported to be “double-blind”, 25 studies were open-label studies. The assessment of the quality of the placebo control, i.e. whether patients, physicians and outcome assessors were truly masked to the treatment, is not included in the current report.

Incomplete outcome data

Drop outs

In all but four studies the numbers and reasons for withdrawal/drop out were reported in the CSRs. Details for the four studies not reporting drop outs: for three studies no clinical study report of full text publication was available and therefore information on number and reason for drop out was not available (Untch 2008; Quirt 1996; Thomas 2002). In the fourth study the number but not the reason for drop outs are reported in the statistical report, a full CSR was not available (Gordon 2006).

Selective reporting

Publication

By June 26 2008, 32 of the included studies had been published as full text, 15 had been published as abstracts only, four studies (CC2574-P-174; EPO-GBR-7; EPO-INT-1; EPO-INT-3) had been reported in the documents of the ODAC hearings in 2004, 2007 or 2008, two studies (EPO-GER-20 and OBE/EPO-INT-03) were unpublished.

For details of the study characteristics see 'Characteristics of studies' table.

Other potential sources of bias

Other design aspects

Study design (endpoint)

Five of the included studies evaluated overall survival as their primary endpoint (Pirker 2008; Aapro 2008; Leyland-Jones 2003; Debus 2006; Untch 2008). Fifteen of the included studies evaluated overall survival as secondary endpoint. In 29 studies survival was assessed as safety or adverse event outcome. For two studies it was not reported whether survival was assessed as an endpoint or not (Dammacco 2001; O'Shaughnessy 2005). However, in both studies deaths were reported in the safety analyses chapters of the clinical study reports and the studies were therefore categorized as “mortality assessed as adverse event only”. One study was categorized as “other” (Smith 2008). In this study deaths were “reported as AEs during the study period but they were also reported during the long-term follow-up and these later deaths were not considered AEs since they occurred outside the AE reporting period” (communication with investigator). This study was categorized as “mortality assessed as adverse events only” in the analysis.

Long-term follow-up

Twenty four studies were planned for a long-term follow-up of at least 12 months post active study phase. Twenty-nine studies did not fulfill this definition. For two of these studies (Ray-Coquard 2006; Wright 2007) the investigator of the respective study had indicated that the study conducted a long-term follow-up, since the available study documents did not report that this follow-up was planned, these studies were evaluated as “not designed for long-term follow-up”. The effect of this potential misclassification can be assessed in a sensitivity analysis.

Completed studies

Of the 53 included studies two studies (Moebus 2007; Untch 2008) were ongoing at the time of analysis. Fourteen of the included

studies were terminated or halted prematurely by its own study protocol definition. Thirty-seven studies were completed by their own study protocol definition.

Missing or not reported data

The amount of missing or not reported data for specific variables is outlined below. The distribution of missing or not reported data was generally not balanced across studies: several variables had not been provided for entire studies. For example for several studies we received no information on documented history of thromboembolic event, hypertension, diabetes mellitus or cardiovascular events, as well as no information of previous or current chemotherapy or radiotherapy. For few studies we had information of the treatment status of the patient, i.e. untreated or in complete response, partial response, stable disease etc, for 71% of the included patients this information was missing. For about 80% of patients we had no structured information on disease stage, i.e. whether the patient had limited, advanced or metastatic disease. The information on stage at diagnosis was therefore generated based on the free text entries per patient and the available study documents (Table 1).

Baseline characteristics and baseline imbalances

Funnel plots were generated to investigate baseline imbalances across all included trials. For continuous variables, means for each trial arm were calculated (active and control arm) and the differences of the means for each study were plotted against the sample size of the corresponding study. For dichotomous variables, proportions for each trial arm were calculated (active and control arm) and the differences of the proportions for each study were plotted against the sample size of the corresponding study. We assessed asymmetry using random-effects meta-regression and derived a corresponding P value (Sterne 2001). Funnel plots include pseudo-95% confidence interval lines, which are drawn around the summary fixed-effect estimate (red lines).

The following variables were assessed:

Continuous: ECOG, level of serum epo, BMI, time from diagnosis of cancer to randomization, hemoglobin, hematocrit, age

Dichotomous: Sex, ECOG (low versus high), history of thromboembolic event, history of cardiovascular event, history of hypertension, history of diabetes.

Plots are shown in Appendix 5. We found no evidence of baseline imbalances across trials.

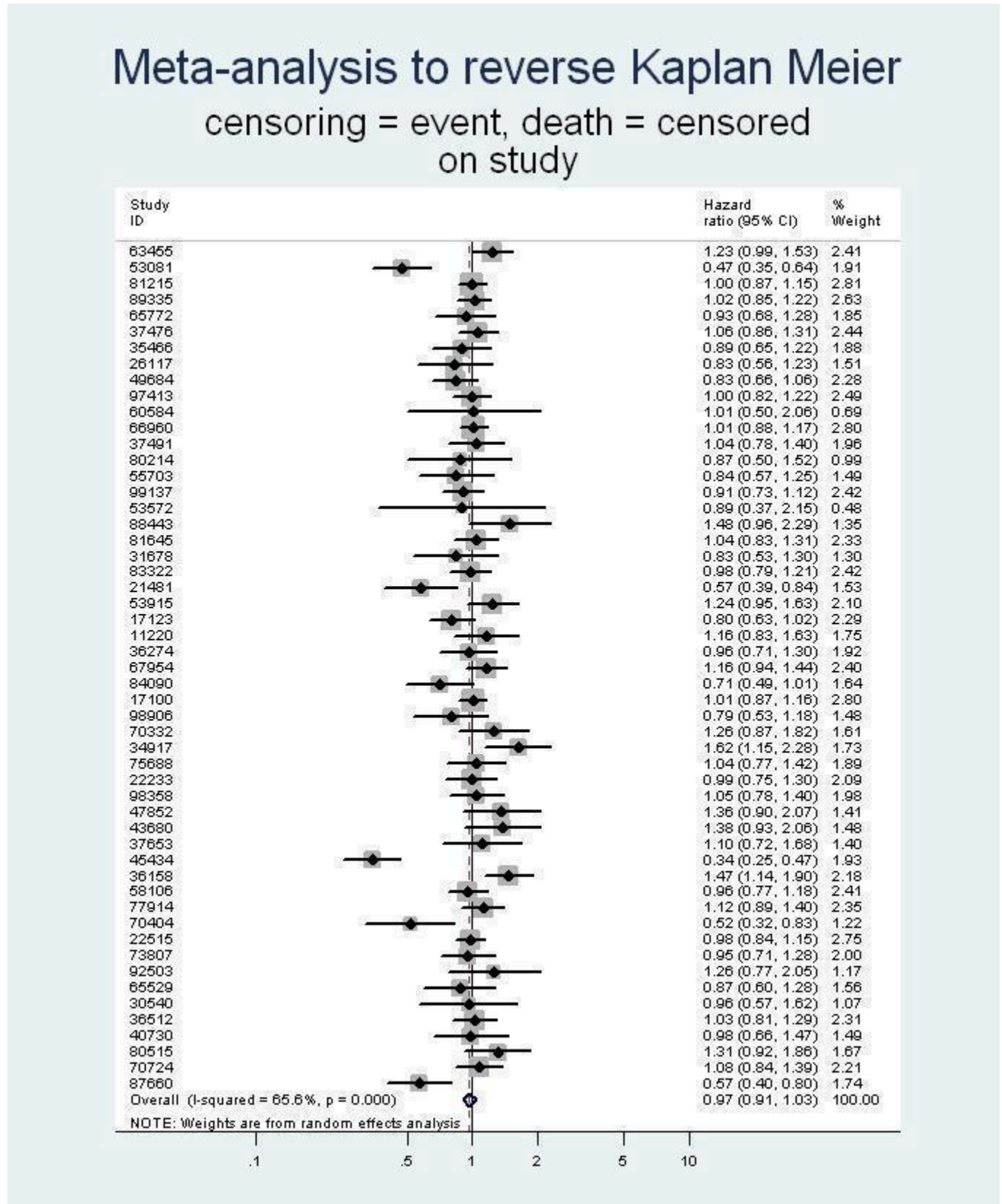
Proportional hazard assumption

For each study we plotted log-log plots for proportional hazard assumption and conducted a Schoenfeld test for residuals. Note: on file, not provided in this review. Overall, in most studies the proportional hazard assumption was fulfilled. In one study (number 43680 (Osterborg 1996)) there was evidence that the proportional hazard assumption was not met (Schoenfeld test $p=0.0309$).

Censoring

Reverse Kaplan-Meier curves to assess time to censoring for each trial are on file. In addition, we calculated the hazard ratio for being censored in the ESA arm compared to the control arm for each study and conducted a meta-analysis based on these estimates. For this analysis patients who were censored in the original trial were considered as an event and patients who died in the original trial were censored for the purpose of this analysis. The meta-analysis was conducted with a two-stage random-effects model and the Forest plot is shown in Figure 5. Overall, there was no evidence for an unbalanced censoring between the ESA and the control arm (HR for being censored when alive 0.97 (95% CI 0.91-1.03)). However, there was evidence for heterogeneity between studies: I^2 65.5%, test for heterogeneity $p<0.0001$. In five studies (53081, 21481, 45434, 70404, 87660) the hazard for being censored was higher in the control arm compared to the ESA arm and in two studies (34917, 36158) patients in the ESA arm were more likely to be censored compared to the control arm. For these studies we compared the hazard ratio of being censored with the hazard ratio for death (Table 2).

Figure 5. On study mortality: censoring meta-analysis, HRs < 1,0 indicate that more patients in the control arm had the event ("censoring"), HRs > 1,0 indicate that more patients in the ESA arm had the event ("censoring") compared to controls.



In addition, we assessed whether in studies with a statistically significant or borderline increased or decreased hazard ratio for on study mortality, the number of censored patients was balanced between the ESA arm and the control arm, see table below. In conclusion, it seems unlikely that unbalanced censoring between the ESA and the control arm has influenced the overall estimates for ESA on mortality (Table 3).

Effects of interventions

On study mortality in all cancer patients

Objective 1 for on study mortality in all cancer patients

Aim: What is the effect of ESAs compared to control for on study mortality in this population and can the effect be explained by baseline imbalances of prognostic factors at patient level?

A total of 53 studies with 13933 patients were included in the analysis of on study mortality. All cancer patients regardless of anticancer treatment received were included in the present analysis. Four studies did not contribute to the present results

because there were no deaths during on study period (study 22515 (Moebus 2007), 30540 (Vadhan-Raj 2004), 66960 (Untch 2008), 70404 (Strauss 2008)).

During on study phase 865 out of 7634 patients randomized to the ESA arm and 665 out of 6299 patients randomized to the control arm died. Median follow-up was 3.71 months (IQR 2.8-5.1 months) in the ESA arm and 3.94 months (IQR 2.9 to 5.3 months) in the control arm. The overall hazard ratio for patients receiving ESA compared to controls was 1.17 (95% CI 1.06-1.30) during on study phase based on two-stage log-rank fixed-effects meta-analysis. Based on a Cox model stratified for study the overall result was 1.17 (95% CI 1.06-1.30). For results of all statistical models applied, see Table 4.

There was no evidence for heterogeneity between the trials (I-square 0%, $p=0.8735$), for Forest plot see Figure 6, for pooled Kaplan-Meier curve see Appendix 4. There was no evidence for small study effects: linear regression test $p=0.1371$, rank correlation test of funnel plot asymmetry $p=0.9588$. For Funnel plot see Figure 7.

Figure 6. Forest plot for on study mortality in all cancer patients based on two stage log-rank fixed-effects meta-analysis

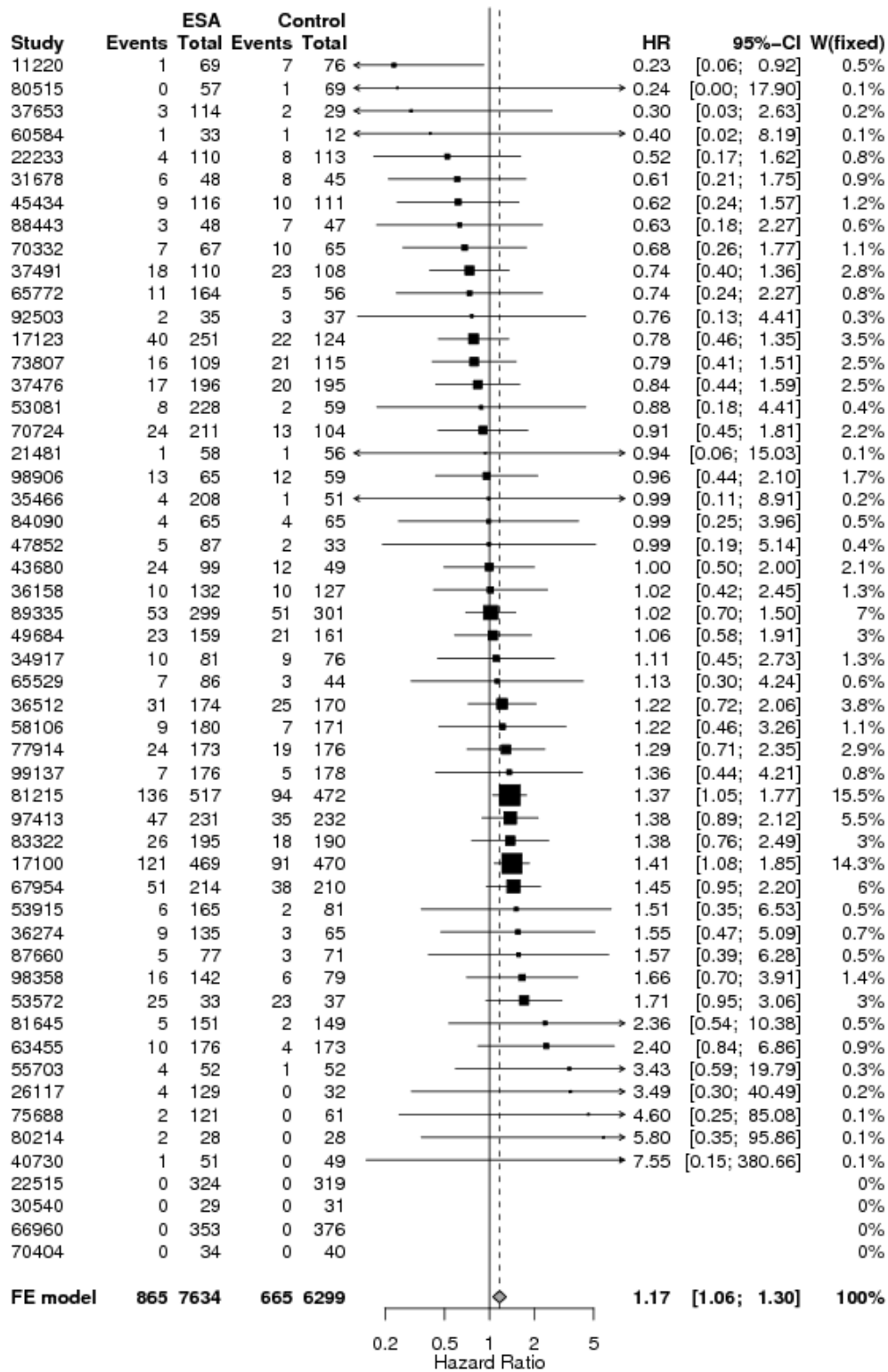
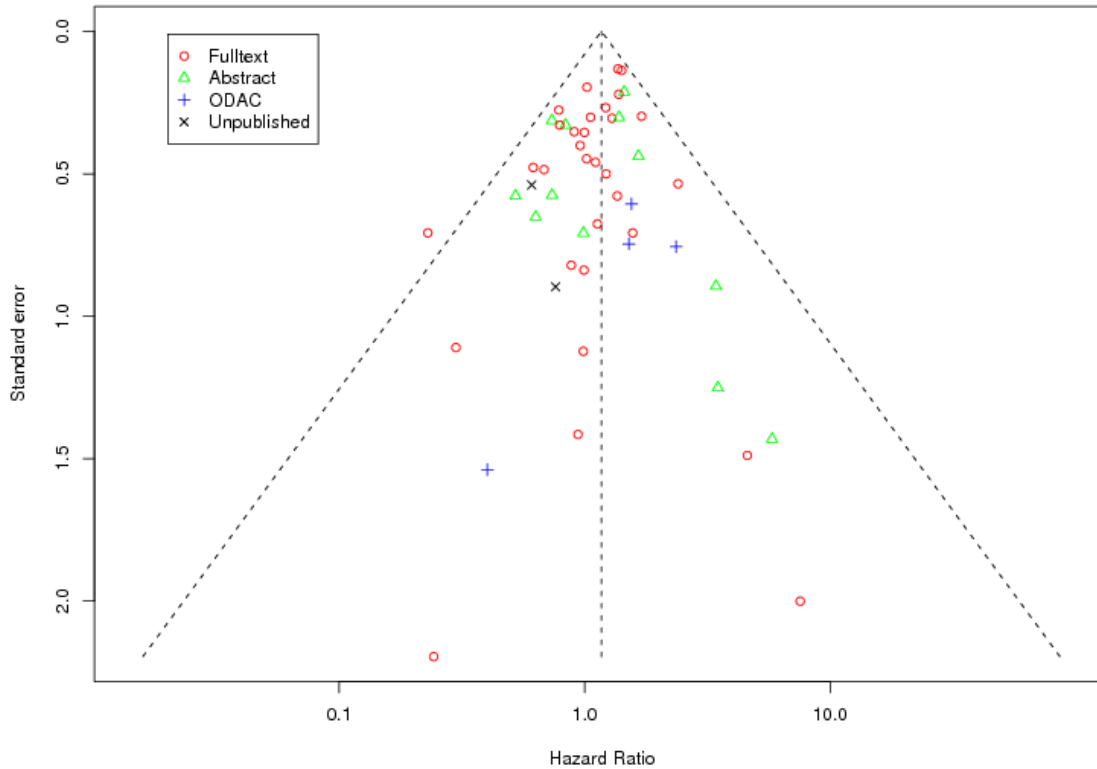


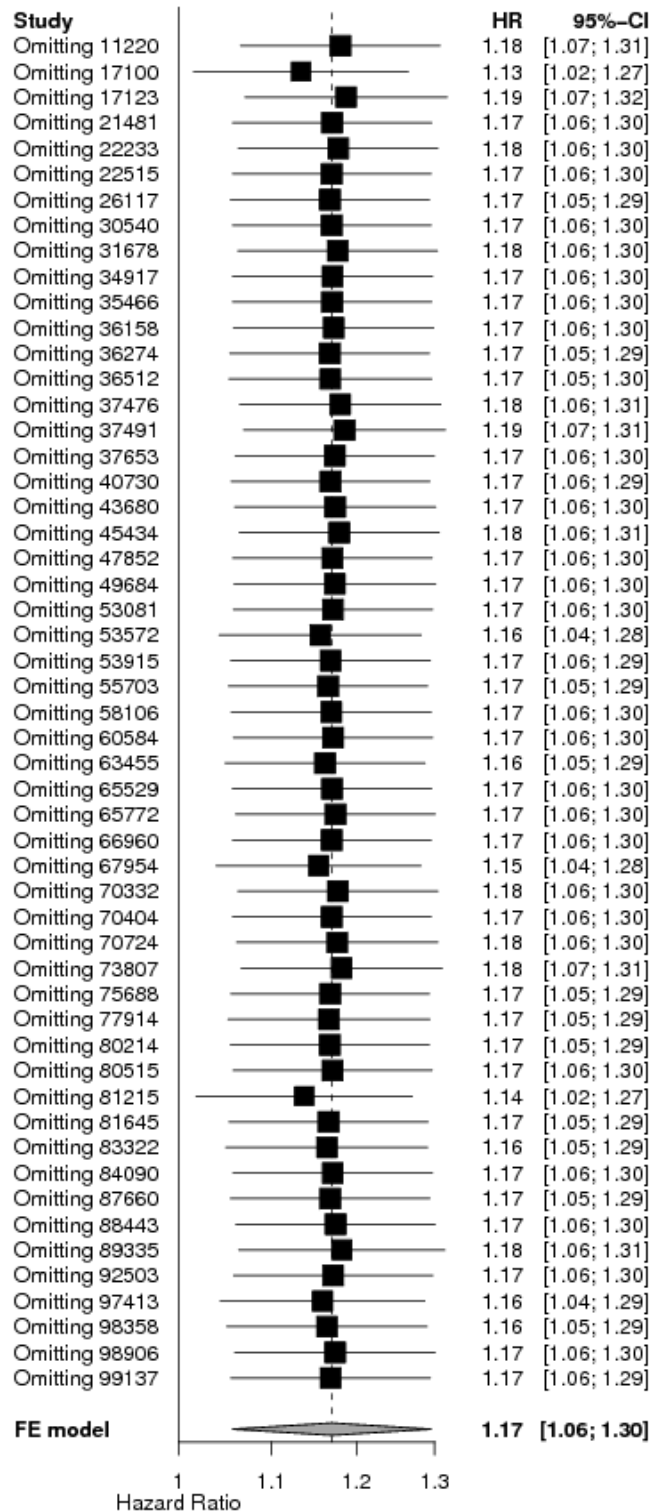
Figure 7. Funnel plot (based on log-rank estimates) for on study mortality in all cancer patients Explanation of terms used: Full text: highest publication achieved is a full text publication Abstract: highest publication achieved is an abstract publication ODAC: highest publication achieved is reporting of study results in documents presented at ODAC hearings Unpublished: to date the study was not published in any of the sources mentioned above Date of reference: June 26th 2008



Two studies contributed more than 10% weight to the overall analysis (Leyland-Jones 2003; Smith 2008). In the study published by Leyland-Jones 2003 (study number 17100) 937 patients with metastatic cancer undergoing chemotherapy received ESA or placebo for 52 weeks, therefore the study has a much longer on study phase compared to other studies. In the study published by Smith et al 2008 (study number 81215) 989 patients were treated

with ESA without concomitant myelosuppressive chemotherapy. The impact of single studies was assessed in an influence analysis, see Figure 8. When excluding study 17100 (Leyland-Jones 2003), the overall HR slightly decreased and the confidence interval still excluded 1. Exclusion of any of the other studies did not markedly change the overall estimate.

Figure 8. Influence analysis for on study mortality in all cancer patients



Assessment of potential confounders for objective 1

In the next step we conducted bivariate analyses: adjusting on study mortality based on the Cox model stratified by study for

one variable at the time. All variables assessed relate to the individual patient data level. The results of the adjusted model were compared with the unadjusted model using LR-Test. Results of

unadjusted and adjusted models as well as P values of LR-Test are shown in [Table 5](#). We included only patients with full information for the respective variable; patients with missing, unknown or unreported data were excluded. Data were often missing for entire studies; therefore the overall HR might have changed because of the omission of studies. We therefore present both unadjusted and adjusted HRs based on the patient data set with available information.

Based on these analyses and the number of data available for each variable, we conducted four different models, all of which are presented in [Table 6](#). For model 1 we included the variables age, sex, and Hb at baseline and tumor type into the model. For model 2 we used the same variables as in model 1 plus stage of underlying tumor. For model 3 we used the same variables as in model 1 plus BMI and region, for model 4 we used the same variables as in model 1 and 3 plus ECOG and hematocrit. For the variables age, Hb, serum EPO and BMI the association between the exposure and the outcome was not linear (graph not shown). Therefore, these continuous variables were converted into prespecified categories. Hematocrit was converted into categories as well for the ease of interpretation. The variable “time for cancer diagnosis to randomization” was not included in the model because of too many missing data.

Summary points for objective 1 for on study mortality in all cancer patients

- ESAs increased on study mortality in cancer patients by factor 1.17 (HR 1.17; 95% CI 1.06-1.30, n =13933).
- Available evidence does not support the hypothesis that baseline imbalances of prognostic factors analyzed influenced the overall results.

Objective 2 for on study mortality in all cancer patients

Aim: Is there a specific subgroup of patients that is at increased or decreased risk to die when receiving ESAs compared to controls? Are there design aspects at study level that influenced the effects of ESA on survival?

We tested for interaction between ESA treatment and specific variables describing patient and study characteristics, results of interaction test are outlined in [Table 7](#), results with estimates for subgroups are outlined in [Appendix 6](#).

Three variables (planned frequency of ESA administration, history of thromboembolic events, hematocrit) showed a statistically significant ($p < 0.1$) interaction term in the bivariate analyses and were included in the multivariate model (model 1). This model included the variables, age and sex, Hb at baseline and tumor category, for P values of LR tests see [Table 8](#).

Summary points for objective 2 for on study mortality in all cancer patients

- There was no strong evidence to support the hypothesis that ESAs had different effects in sub-populations that differed for any of the variables tested.
- For three variables (ESA administration frequency, history of thromboembolic events, and hematocrit) found statistically significant ($p < 0.1$) in bivariate analyses multivariate analyses suggested the following:
 - Effect modification of Hct at baseline can only to a certain extent be explained by confounding with other patient characteristics (Hb, age, sex, tumor type). However, because of large amounts of missing data uncertainty remains.
 - Effect modification of history of thromboembolic events was robust in sensitivity analyses for additional patient characteristics (Hb, age, sex, tumor type); however, because of large amounts of missing data uncertainty remains.
 - Effect modification for planned frequency of ESA application is likely to be confounded by other study design aspects, see [Appendix 4](#).

On study mortality in chemotherapy trials

Objective 1 for on study mortality in chemotherapy trials

Aim: What is the effect of ESAs compared to control for on study mortality in this population and can the effect be explained by baseline imbalances of prognostic factors?

A total of 38 studies with 10441 patients were included in the analysis of on study mortality analysis in patients undergoing chemotherapy. In this analysis we included only studies where at least 70% of the study population had received a myelosuppressive chemotherapy. Two studies did not contribute to the present results because there were no deaths during on study period (study 22515 ([Moebus 2007](#)), 66960 ([Untch 2008](#))).

During on study phase 605 out of 5676 patients randomized to the ESA arm and 490 out of 4765 patients randomized to the control arm died. Median follow-up was 4.1 months (IQR 3.0 to 5.6 months) in the ESA and 4.3 months (IQR 3.4 to 5.7 months) in the control arm. The overall hazard ratio for patients receiving ESAs compared to controls was 1.10 (95% CI 0.98-1.24) during on study phase based on the two-stage log-rank fixed-effects meta-analysis. Based on a Cox model stratified for study the overall result was 1.10 (95% CI 0.98-1.24). For results of all statistical models applied see [Table 9](#). For Forest plot see [Figure 9](#), for pooled Kaplan-Meier curve see [Appendix 4](#). There was no evidence for heterogeneity between the trials (I-square 0%, $p = 0.7152$). There was no evidence for small study effects: linear regression test $p = 0.1743$, rank correlation test of funnel plot asymmetry $p = 0.7437$. For Funnel plot see [Figure 10](#).

Figure 9. Forest plot for on study mortality in chemotherapy trials based on two-stage log-rank fixed-effect meta-analysis

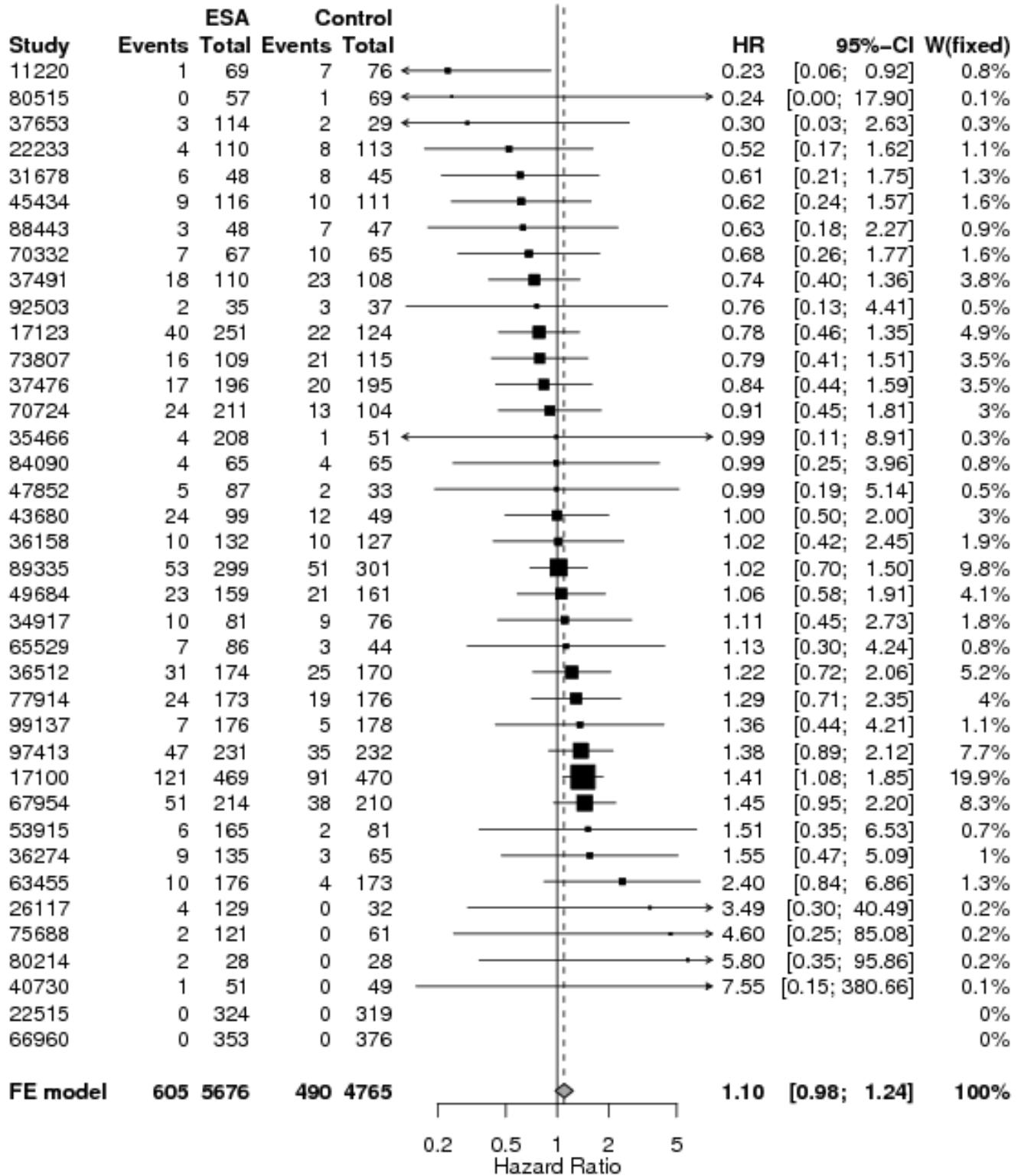
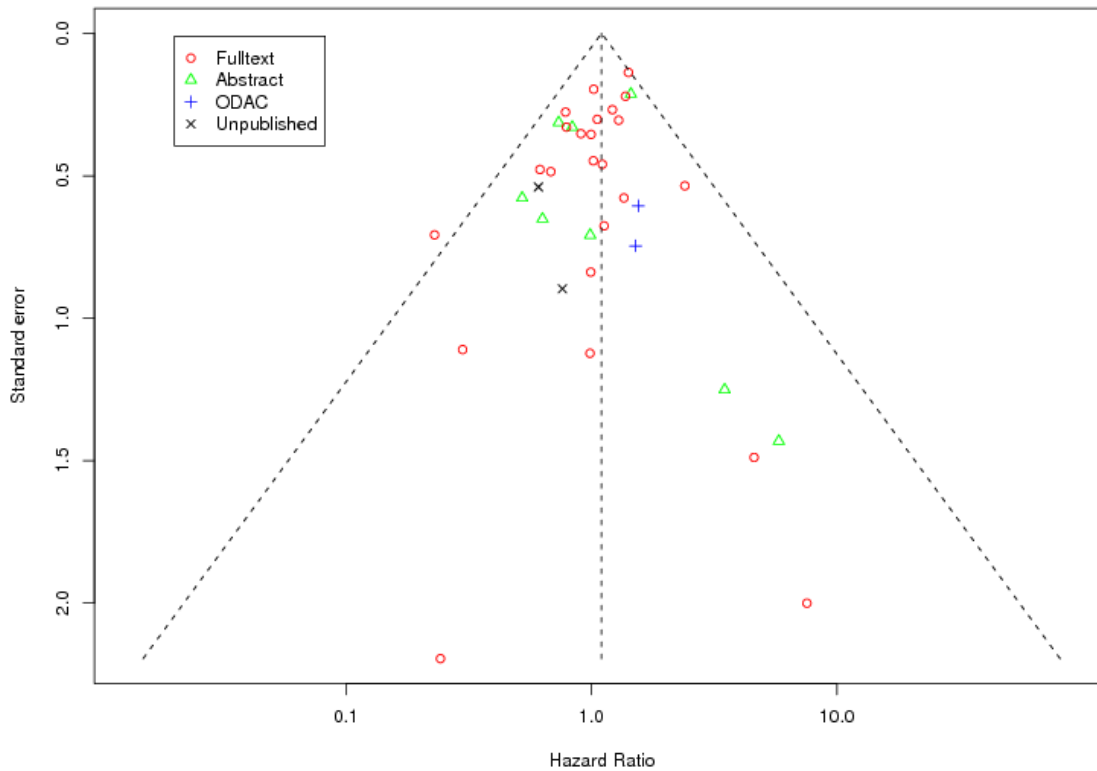


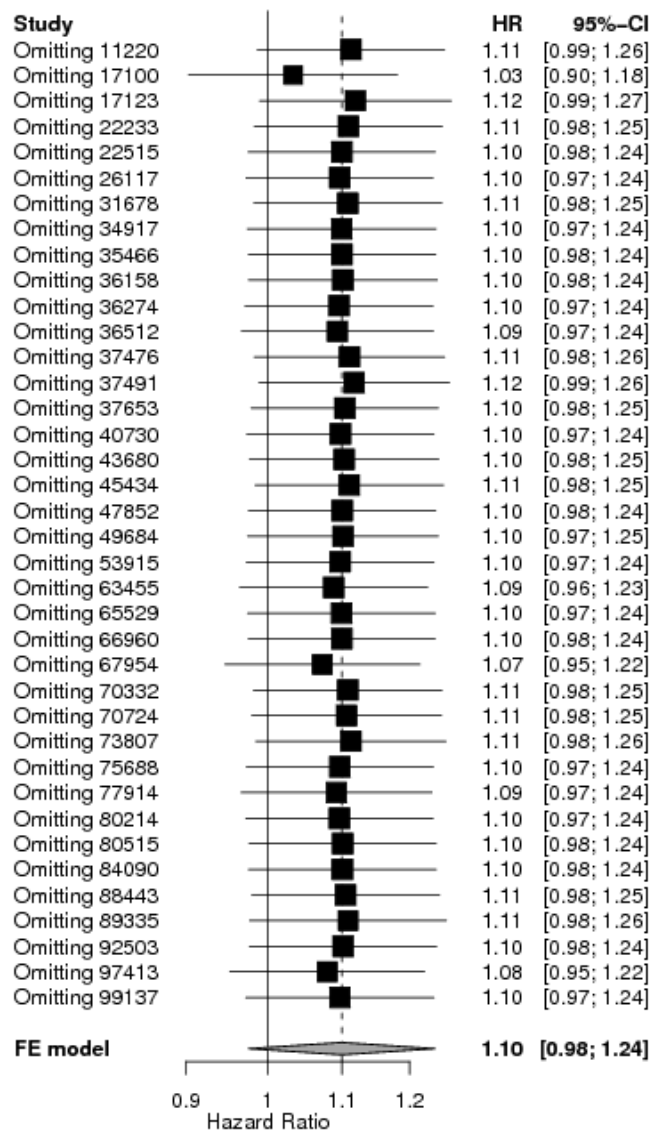
Figure 10. Funnel plot (based on log-rank estimates) for on study mortality in chemotherapy trials Explanation of terms: Full text: highest publication achieved is a full text publication Abstract: highest publication achieved is an abstract publication ODAC: highest publication achieved is reporting of study results in documents presented at ODAC hearings Unpublished: to date the study was not published in any of the sources mentioned above Date of reference: June 26th 2008



One study contributed 19.9% weight to the overall analysis (Leyland-Jones 2003). As described above, in the study published by Leyland-Jones et al 2003 (study 17100) 937 patients with metastatic cancer undergoing chemotherapy received ESA or placebo for 52 weeks, therefore the study has a much longer on

study phase compared to other studies. The influence of single studies was assessed in an influence analysis, see Figure 11. Excluding study 17100 decreased the overall HR (omitting 17100: HR 1.03 (95% CI 0.90-1.18); the margins of the confidence intervals were not influenced by exclusion of any of the other studies.

Figure 11. Influence analysis for on study mortality in chemotherapy trials



Assessment of potential confounders for objective 1

In the next step we conducted bivariate analyses: adjusting on study mortality based on the Cox model stratified by study for one variable at the time. All variables assessed relate to the individual patient data level. The results of the adjusted model were compared with the unadjusted model using LR-Test. Results of unadjusted and adjusted models as well as P values of LR-Test are shown in Table 10. We included only patients with full information for the respective variable; patients with missing, unknown or unreported data were excluded. Data were often missing for entire studies; exclusion of these studies might have affected the overall estimate. We therefore present both unadjusted and adjusted HRs for the full patient data set for each variable.

Based on these analyses and the number of data available for each variable, we conducted four different models, all of which are presented in Table 11. For model 1 we included the variables age, sex, and Hb at baseline and tumor type into the model. For model 2 we used the same variables as in model 1 plus tumor stage. For model 3 we used the same variables as in model 1 plus BMI and region, for model 4 we used the same variables as in model 1 and 3 plus ECOG and hematocrit. For the continuous variables age, Hb, serum EPO and BMI the association between the exposure and the outcome was not linear (graph not shown). Therefore, these continuous variables were converted into prespecified categories. Hematocrit was converted into categories as well for the ease of interpretation. When including history of cardiovascular events into model 1, the overall effect was also not altered (data on file, not shown).

Summary points for objective 1 for on study mortality in chemotherapy trials

- The hazard ratio for on study mortality in the chemotherapy population is increased by factor 1.10 for patients receiving ESAs compared to controls (HR 1.10, 95% CI 0.98-1.24, n=10441). The evidence does not conclusively demonstrate that ESAs increase on study mortality but the evidence also does not conclusively exclude a harmful effect in this population.
- Available evidence does not support the hypothesis that baseline imbalances of prognostic factors analyzed influenced the overall results.

Objective 2 for on study mortality in chemotherapy trials

Aim: Is there a specific subgroup of patients that is at increased or decreased risk to die when receiving ESAs compared to controls? Are there design aspects at study level that influenced the effects of ESA on survival?

We tested for interaction between ESA treatment and specific variables describing patient and study characteristics, results for interaction tests are shown in [Table 12](#), results for effect estimates of subgroups are outlined in [Appendix 7](#).

Two variables (concealment of allocation, planned frequency of ESA administration) showed a statistically significant ($p < 0.1$) interaction term in the bivariate analysis and were included in the multivariate model (model 1). This model (model 1) included the variables, age and sex, Hb at baseline and tumor category, see [Table 13](#). Adjusting for these parameters did not markedly influence the effect estimates and the P values for interaction.

Summary points for objective 2 for on study mortality in chemotherapy trials

- For two variables (ESA administration frequency, concealment of allocation) found statistically significant ($p < 0.1$) in bivariate analyses multivariate adjustments did not markedly effect the estimates and the corresponding P values for interaction.
- For both variables statistical tests for interaction had borderline significance only in both bivariate and multivariate analyses.
- Overall, there is no strong evidence to support the hypothesis that ESAs had different effects in sub-populations that differed for the variables tested in the chemotherapy population.

Overall survival in all cancer patients

Objective 1 for overall survival in all cancer patients

Aim: What is the effect of ESAs compared to control on overall survival in this population and can the effect be explained by baseline imbalances of prognostic factors at patient level?

53 studies with 13933 patients were included in the analysis of overall survival for all cancer patients. 2643 out of 7634 patients randomized to ESA and 2350 out of 6299 patients randomized to control died during longest follow-up available. Median follow-up was 6.2 months (IQR 3.2 to 15.4 months) in the ESA and 8.3 months (IQR 3.7 to 19.6 months) in the control arm. The overall hazard ratio for patients receiving ESA compared to controls was 1.06 (95% CI 1.00-1.12) for longest follow-up available based on the two-stage log-rank fixed-effects model meta-analysis. Based on a Cox model stratified for study the overall result was 1.06 (95% CI 1.00-1.12). For results of all statistical models applied see [Table 14](#). There was no evidence for heterogeneity between the trials (I-square 7.1%, $p=0.3288$). For Forest plot see [Figure 12](#), for pooled Kaplan-Meier curve see [Appendix 4](#). There was no evidence for small study effects: linear regression test $p=0.7567$, rank correlation test of funnel plot asymmetry $p=0.602$. For Funnel plot see [Figure 13](#).

Figure 12. Forest plot for overall survival in all cancer patients based on two-stage log-rank fixed effect meta-analysis

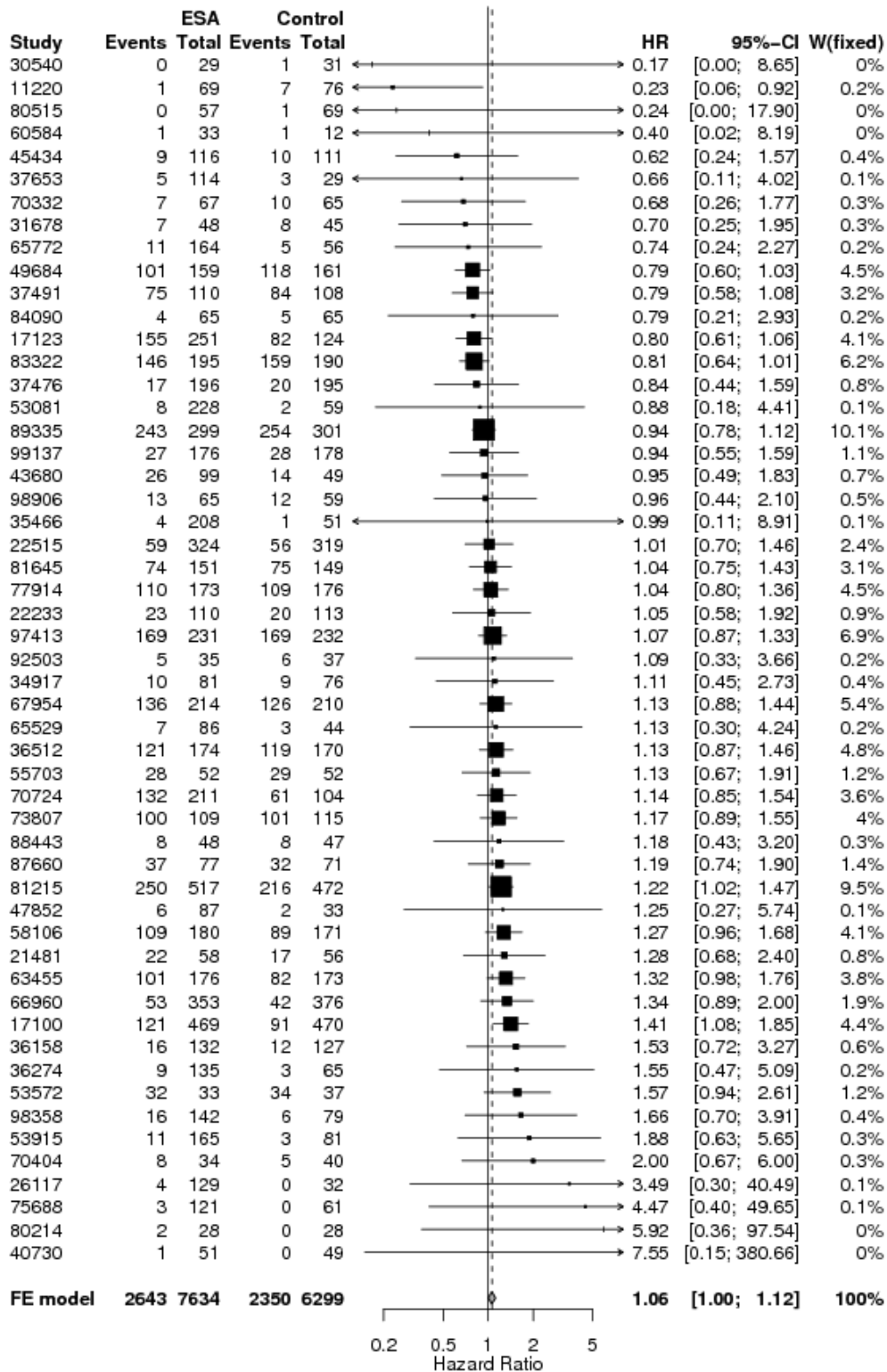
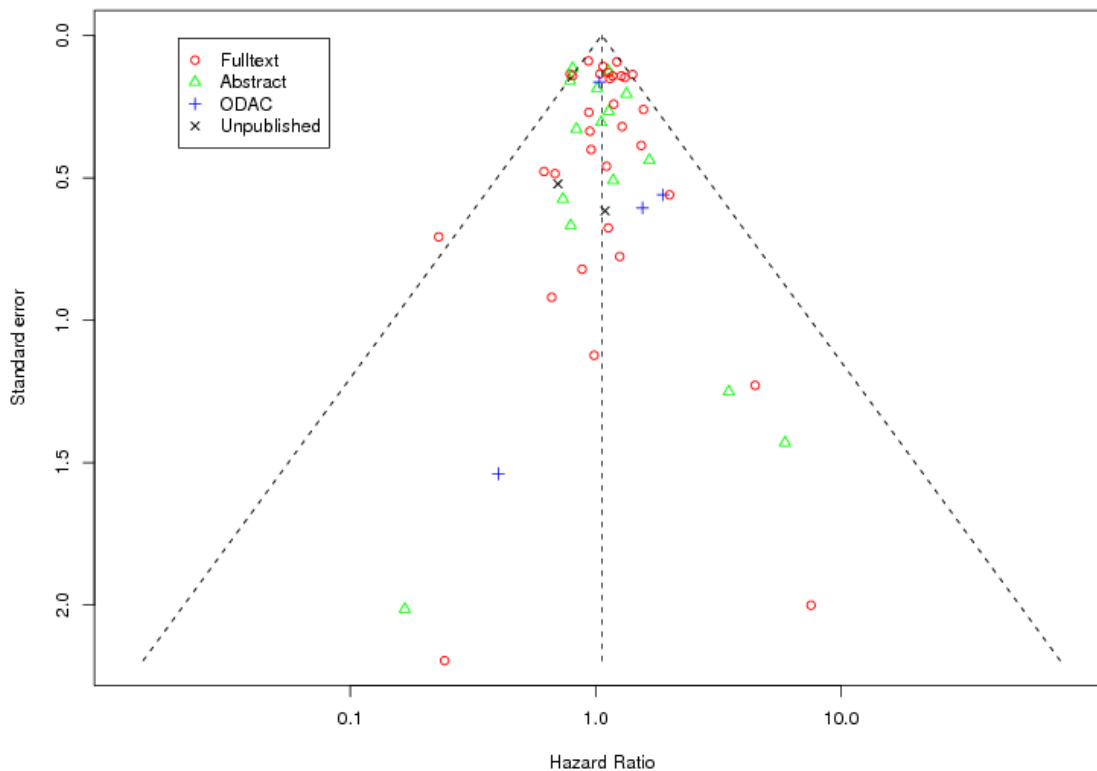


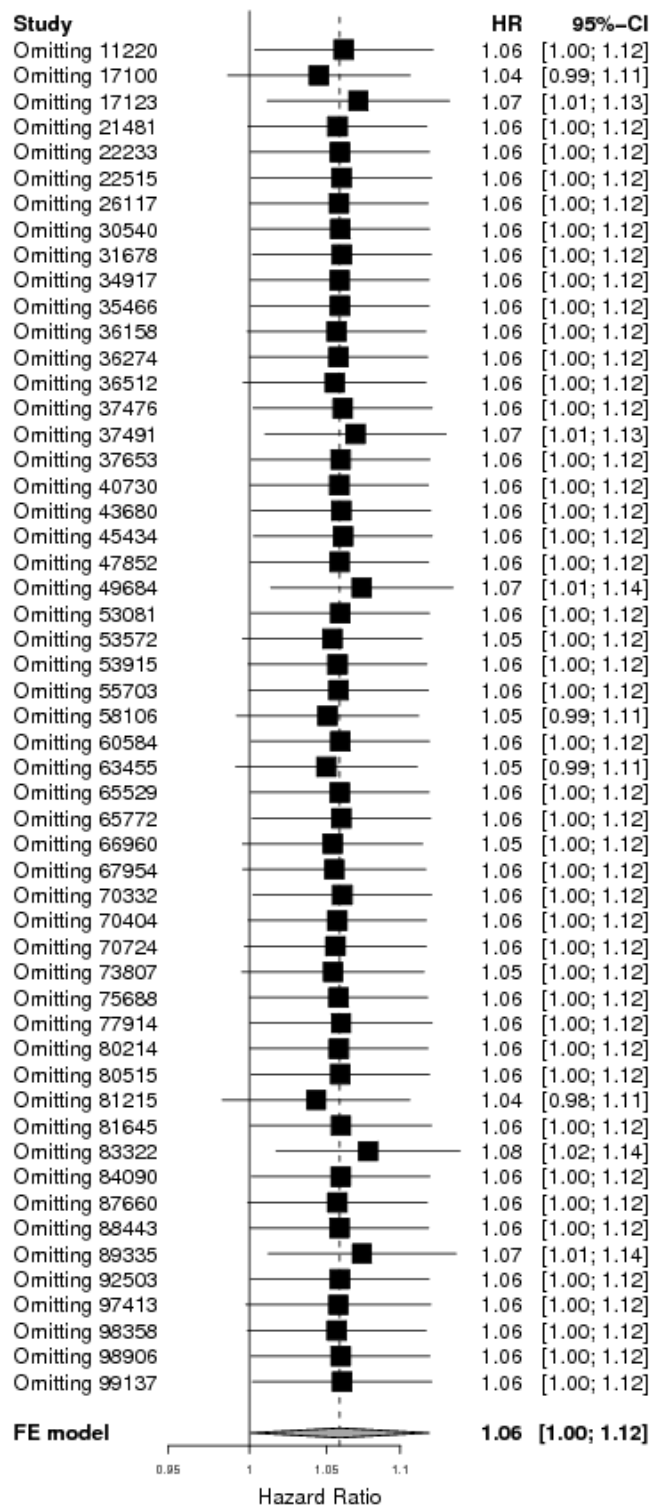
Figure 13. Funnel plot (based on log-rank estimates) for overall survival in all cancer patients Explanation of terms used: Full text: highest publication achieved is a full text publication Abstract: highest publication achieved is an abstract publication ODAC: highest publication achieved is reporting of study results in documents presented at ODAC hearings Unpublished: to date the study was not published in any of the sources mentioned above Date of reference: June 26th 2008



Overall, 24 of the 53 included trials were designed for long-term follow-up, defined as planned follow-up of at least 12 months after end of treatment phase. 14 of the 53 included studies (all of which were designed for long-term follow-up) had a median follow-up of at least 12 months. Tables providing median follow-up for both on study mortality and overall survival per study are on file. Results for studies designed for long-term follow-up as well as other sensitivity analyses are provided in [Appendix 3](#).

Two studies contributed 9.5% and 10.1% weight to the overall analysis ([Pirker 2008](#)), ([Smith 2008](#)). In the study published by [Smith 2008](#) (study number 81215) 989 patients were treated with ESA or placebo without concomitant myelosuppressive chemotherapy. In the study published by ([Pirker 2008](#)) (study number 89335) 600 patients with untreated, extensive SCLC underwent chemotherapy and were randomized to receive ESA or placebo. The influence of single studies was assessed; see [Figure 14](#), exclusion of single studies at a time did not influence the overall result.

Figure 14. Influence analysis for overall survival in all cancer patients



Assessment of potential confounders for objective 1

In the next step we conducted bivariate analyses: adjusting overall survival based on the Cox model stratified by study for one variable

at the time. All variables assessed relate to the individual patient data level. The results of the adjusted model were compared with the unadjusted model using LR-Test. Number of patients included

per variable and P values of LR-Test are shown in [Table 15](#). We included only patients with full information for the respective variable; patients with missing, unknown or unreported data were excluded. Data were often missing for entire studies; therefore the overall HR might have changed because of the omission of studies. We therefore present both unadjusted and adjusted HRs based on the patient data set with available information.

Based on these analyses and the number of data available for each variable, we conducted four different models, all of which are presented in [Table 16](#). For model 1 we included the variables age, sex, Hb at baseline and tumor type into the model. For model 2 we used the same variables as in model 1 plus tumor stage. For model 3 we used the same variables as in model 1 plus BMI and region, for model 4 we used the same variables as in model 1 and 3 plus ECOG and hematocrit. For the continuous variables age, Hb, serum EPO and BMI the association between the exposure and the outcome was not linear (graph not shown). Therefore, these continuous variables were converted into prespecified categories. Hematocrit was converted into categories as well for the ease of interpretation. The variables serum EPO and time from cancer diagnosis to randomization were excluded because too many data were missing. When history of thromboembolic events and history of cardiovascular events were included in model 1 (each at a time), the overall results were also not changed (data on file).

Summary points for objective 1:

- Across all cancer patients analyzed, ESAs increase the risk for mortality over longest available follow-up when compared with controls (HR 1.06, 95% CI 1.00-1.12, n=13933).
- Available evidence does not support the hypothesis that baseline imbalances of prognostic factors analyzed influenced the overall results.

Objective 2 for overall survival in all cancer patients

Aim: Is there a specific subgroup of patients that is at increased or decreased risk to die when receiving ESAs compared to controls? Are there design aspects at study level that influenced the effects of ESA on survival?

We tested for interaction between ESA treatment and specific variables describing patient and study characteristics, results are outlined in [Table 17](#), results with subgroup effects are outlined in [Appendix 8](#).

Two variables (planned frequency, Hct at baseline) showed a statistically significant ($p < 0.1$) interaction term in the bivariate

analysis and was included in the multivariate model (model 1). This model (model 1) included the variables, age and sex, Hb at baseline and tumor category; for P values of LR test see [Table 18](#).

Summary points for objective 2 for overall survival in all cancer patients

- Two variables (ESA administration frequency, Hct at baseline) were found to be statistically significant ($p < 0.1$) in bivariate analyses. Multivariate adjustments did not markedly effect the estimates; however, corresponding P values for interaction did not reach conventional levels of significance."
- Overall, available evidence does not support the hypothesis that ESAs had different effects in sub-populations that differed for any of the variables tested for overall survival in all cancer patients.

Objective 1 for overall survival in chemotherapy trials

Aim: What is the effect of ESAs compared to control on overall survival in this population and can the effect be explained by baseline imbalances of prognostic factors?

A total of 38 studies with 10441 patients were included in the overall survival analysis of patients undergoing chemotherapy. In this analysis we included only studies where at least 70% of the study population had received a myelosuppressive chemotherapy.

1888 out of 5676 patients randomized to ESA and 1667 out of 4765 patients randomized to controls died during on study phase and subsequent follow-up. Median follow-up was 6.7 months (IQR 3.4 to 15.7 months) in the ESA and 8.4 months (IQR 3.7 to 19.1 months) in the control arm. The hazard ratio for overall survival in chemotherapy patients receiving ESA compared to controls was 1.04 (95% CI 0.97-1.11) based on the two-stage log-rank fixed-effects meta-analysis. Based on a Cox model stratified for study the overall result was 1.04 (95% CI 0.97-1.11). For results of all statistical models applied see [Table 19](#). For Forest plot see [Figure 15](#), for pooled Kaplan-Meier curve see [Appendix 4](#). There was no evidence for heterogeneity between the trials (I-square 5.3%, $p = 0.3775$). There was no evidence for small study effects: linear regression test $p = 0.7008$, rank correlation test of funnel plot asymmetry $p = 0.6782$. For Funnel plot see [Figure 16](#). One study contributed about 14% weight to the overall analysis ([Pirker 2008](#)). In this study ([Pirker 2008](#)) (study number 89335) 600 patients with untreated, extensive SCLC underwent chemotherapy and were randomized to receive ESA or placebo. Exclusion of single studies at a time did only marginally influence the overall results, see influence analysis [Figure 17](#).

Figure 15. Forest plot for overall survival in chemotherapy trials based on two-stage log-rank fixed-effect meta-analysis

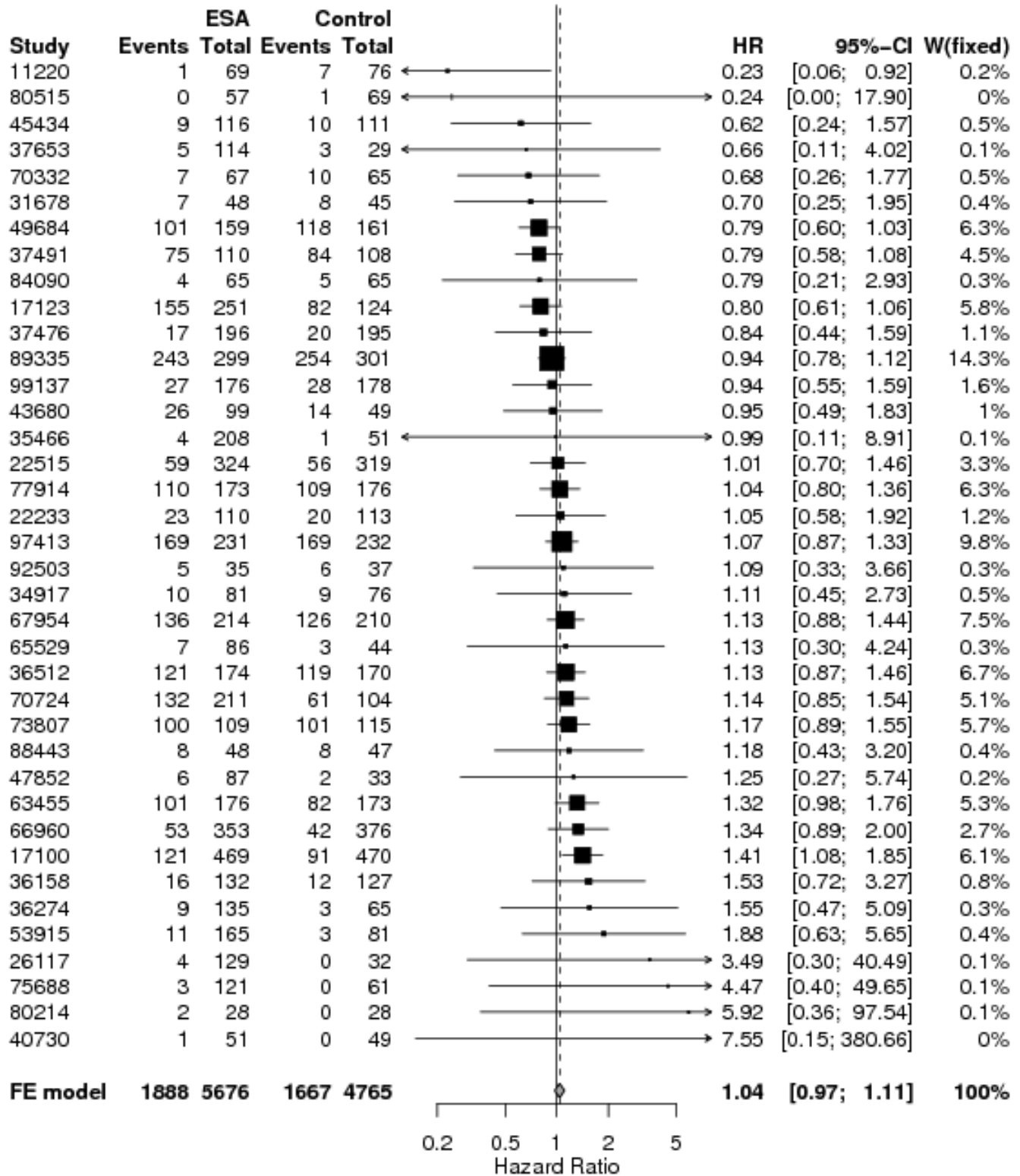


Figure 16. Funnel plot (based on log-rank estimates) for overall survival in chemotherapy trials (subset analysis)
Explanation of terms used: Full text: highest publication achieved is a full text publication Abstract: highest publication achieved is an abstract publication ODAC: highest publication achieved is reporting of study results in documents presented at ODAC hearings Unpublished: to date the study was not published in any of the sources mentioned above Date of reference: June 26th 2008

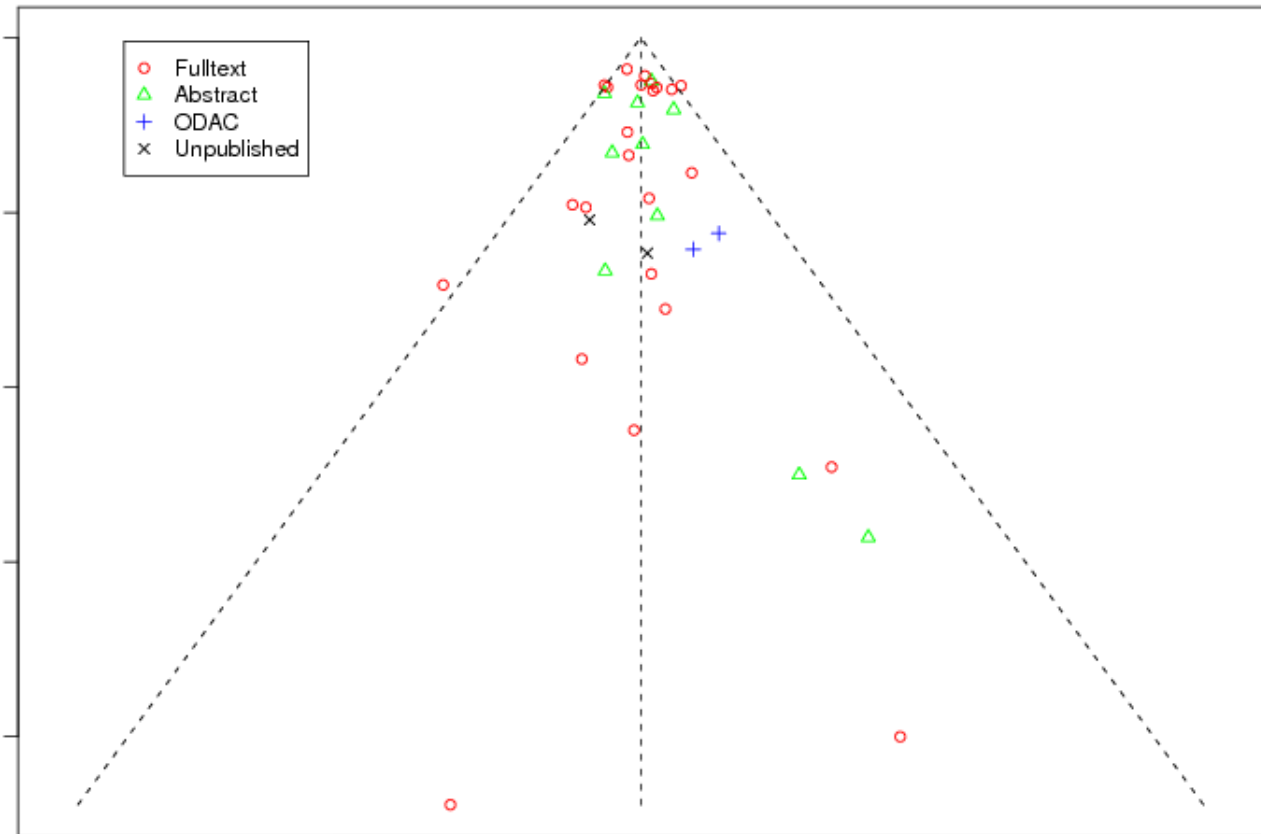
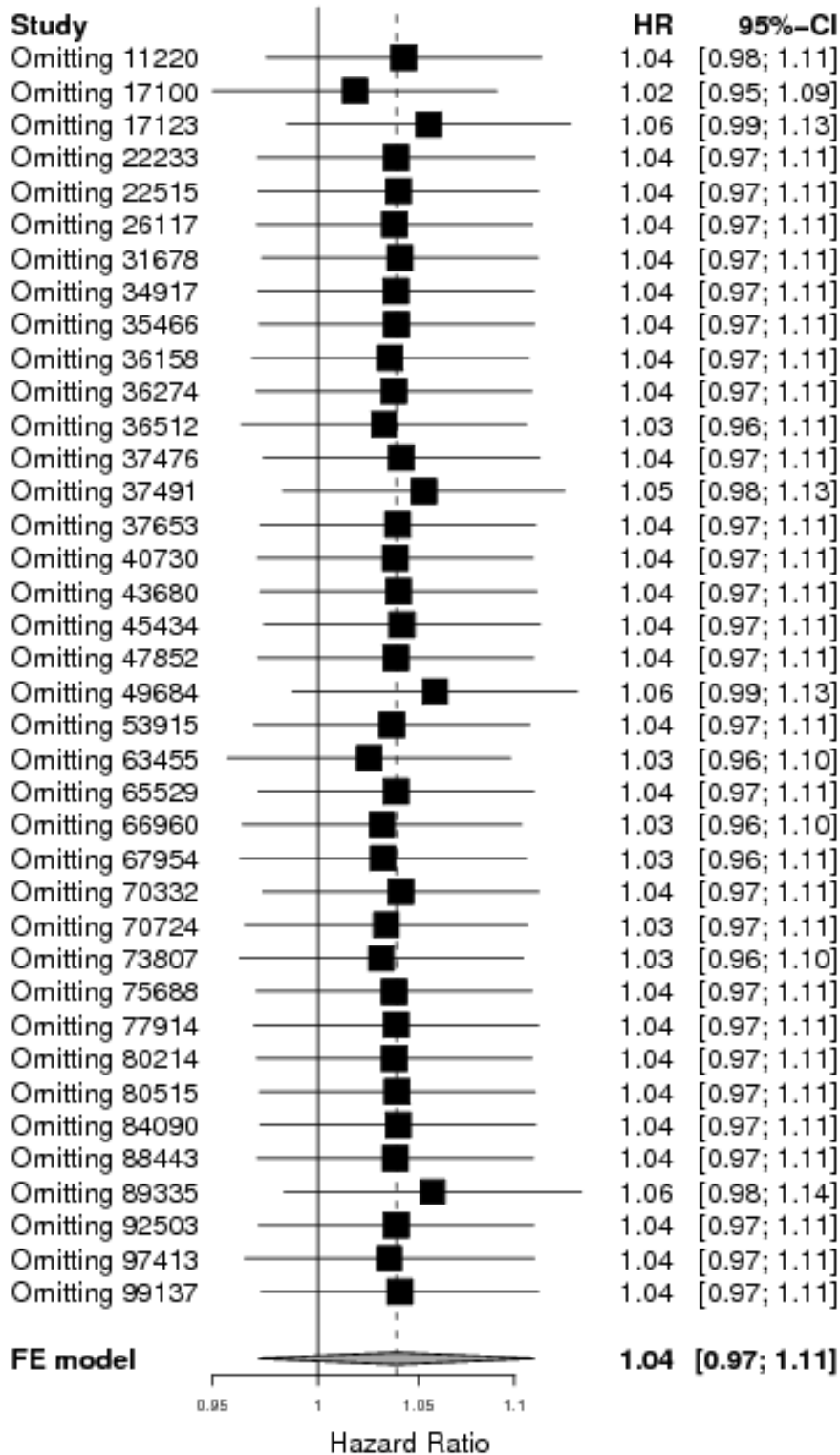


Figure 17. Influence analysis for overall survival in chemotherapy trials



Assessment of potential confounders for objective 1

In the next step we conducted bivariate analyses: adjusting overall survival based on the Cox model stratified by study for one variable at the time. All variables assessed relate to the individual patient data level. The results of the adjusted model were compared with the unadjusted model using LR-Test. Results of unadjusted and adjusted models as well as P values of LR-Test are shown in [Table 20](#). We included only patients with full information for the respective variable; patients with missing, unknown or unreported data were excluded. Data were often missing for entire studies; therefore the overall HR might change because of the omission of specific studies. We therefore present both unadjusted and adjusted HRs based on the patient data set available for each variable.

Based on these analyses and the number of data available for each variable, we conducted four different models, all of which are presented in [Table 21](#). For model 1 we included the variables age, sex, and Hb at baseline and tumor type into the model. For model 2 we used the same variables as in model 1 plus tumor stage. For model 3 we used the same variables as in model 1 plus BMI and region, for model 4 we used the same variables as in model 1 and 3 plus ECOG and hematocrit. For the continuous variables age, Hb, serum EPO and BMI the association between the exposure and the outcome was not linear (graph not shown). Therefore, these continuous variables were converted into prespecified categories. Hematocrit was converted into categories as well for the ease of interpretation. When history of thromboembolic events, history of cardiovascular events and history of diabetes mellitus were included in model 1 (each at a time) the overall results were also not altered (data on file).

Summary points for objective 1 overall survival in chemotherapy trials

- Across studies with >70% of patients receiving chemotherapy, ESA treatment appeared to slightly increase the risk of mortality over longest available follow-up (HR 1.04, 95% CI 0.97-1.11, n=10441).
- Available evidence does not support the hypothesis that baseline imbalances of prognostic factors analyzed influenced the overall results.

Objective 2 for overall survival in chemotherapy trials

Aim: Is there a specific subgroup of patients that is at increased or decreased risk to die when receiving ESAs compared to controls? Are there design aspects at study level that influenced the effects of ESA on survival?

We conducted subgroup analyses for each patient and study characteristic variable at the time and tested for interaction between ESA treatment and specific variables describing patient and study characteristics. Results of tests for interactions are outlined in [Table 22](#), results for subgroup estimates are outlined in [Appendix 9](#).

Only one variable (sex) showed a statistically significant interaction term in the bivariate analysis. Women were at increased risk to die when receiving ESAs (HR 1.10, 95% CI 1.01-1.21) compared to men (HR 0.96, 95% CI 0.87-1.06, P value for interaction: 0.0370). When adjusting in addition for age, Hb at baseline and tumor category, the modifying effect for sex remained (P value for interaction 0.0362) ([Table 23](#)). For additional exploratory analyses see [Appendix 4](#).

Summary points for objective 2 for overall survival in chemotherapy patients

- Within the chemotherapy population there was no convincing evidence to support the hypothesis that ESAs had different effects in sub-populations that differed for any of the variables tested.
- However, effect modification of sex cannot be explained by confounding with other patient characteristics (Hb, age, sex, tumor type), see also [Appendix 4](#).

Survival at predefined time points

In addition to the endpoints “on study mortality” and “overall survival”, we specifically examined the following prespecified time points: survival at 4, 8, 12, 24, 36 and 60 months after randomization. We conducted these analyses in two different data sets: one analysis was based on the “on study mortality” data set. In this data set all patients were censored after the end of active treatment plus a follow-up window of 28 days. In contrast in the overall survival analysis patients were followed up after the end of active study treatment phase (exception: studies with “cross-over” after end of study period). When comparing the numbers of death at specific time points, the number of patients who died was higher in the overall survival data set compared to the on study mortality data set at 4, 8 and 12 months. The point estimates for HRs of overall survival appear smaller, but confidence intervals are wide, with substantial overlap. Several reasons might explain this observation: patients in both active and control arm might have received ESAs after end of study period, the underlying disease might dominate the picture after the end of ESA treatment and there might be losses to follow-up since not all studies were designed for a long-term active follow-up. We conducted a sensitivity analysis for studies, which had an active follow-up after the end of ESA treatment period at least additional 12 months, see [Appendix 3](#).

Survival at predefined time points: including all studies

see [Table 24](#), [Table 25](#), [Table 26](#), and [Table 27](#)

Sensitivity analysis: survival at predefined time points including only studies with long-term follow-up

The outputs of [Table 28](#), [Table 29](#), [Table 30](#), [Table 31](#), [Table 32](#), and [Table 33](#) were restricted to studies that were designed for long-term follow-up. Long-term follow-up was defined as follow-up of at least 12 months after end of treatment phase.

Sensitivity analyses

see [Appendix 3](#)

Exploratory analyses

see [Appendix 4](#)

Clinical relevance

To calculate the number needed to treat for an additional harmful outcome (NNTH) we applied the overall estimate for on study mortality for all cancer patients (HR 1.17; 95% CI 1.06 to 1.30) to different hypothetical cancer populations ([Altman 1999](#)). With an underlying survival probability of 95% at one year it is expected that one additional person may die for every 121 participants randomized to receive ESAs (NNTH 121, 95% CI 69 to 343). With an underlying survival probability of 80% the NNTH is 34 (95% CI 19 to

94) and 24 (95% CI 14 to 67) for a survival probability of 70%, see [Table 34](#).

We also calculated the number needed to treat for an additional harmful outcome (NNTH) for the on study mortality estimate from chemotherapy trials. Note: the confidence intervals for this estimate include 1.0 which requires special consideration when calculating confidence intervals for numbers needed to treat ([Altman 1998](#)). We applied the overall estimate for on study mortality from chemotherapy trials (HR 1.10; 95% CI 0.98 to 1.24) to different hypothetical cancer populations ([Altman 1999](#)). With an underlying survival probability of 95% at one year it is expected that one additional person may die for every 206 participants randomized to receive ESAs (95% CI NNTH 86 to ∞ to NNTB 1026). With an underlying survival probability of 80% the NNTH is 57 (95% CI NNTH 24 to ∞ to NNTB 279) and 41 (95% CI NNTH 17 to ∞ to NNTB 200) for a survival probability of 70%, see also [Table 34](#).

DISCUSSION

Summary of main results

This individual patient data meta-analysis of 53 randomized clinical trials in cancer patients found that ESAs caused an estimated 17% increase in mortality relative to control during the study period and a relative increase of 6% when the longest available follow-up was considered. The increase in mortality was less pronounced in patients receiving chemotherapy, but this difference is likely to be the product of chance.

Overall completeness and applicability of evidence

Our analysis has a number of strengths. It was based on individual patient data from 13933 patients who were enrolled in trials conducted by manufacturers and independent investigators. We had access to the study protocols and clinical study reports. All analyses were based on the intention-to-treat principle, i.e. all patients were evaluated in the treatment groups assigned at randomization; analyses were conducted in duplicate by two independent, experienced groups. Only factors known before the onset of treatment were considered as candidate effect modifiers. A striking finding was that although the studies included clinically diverse populations, and different ESA regimens, we detected very little, if any heterogeneity between trials. Sensitivity analyses confirmed the robustness of the overall results.

Potential biases in the review process

Data were not available for some trials, in particular RCTs with radiotherapy or radiochemotherapy ([Overgaard 2007](#); [Bloher 2003](#); [Antonadou 2001](#)). However, inclusion of these studies based on the results published in the literature did not change the overall estimates. An important finding of this study is the absence of strong modifiers of the effect of ESAs on mortality. Given the large data set analyzed it seems unlikely that larger differences were missed. However, uncertainty remains since smaller differences in effects cannot be excluded with confidence.

Agreements and disagreements with other studies or reviews

While most literature-based meta-analyses are limited by access to aggregated data at study level only, our IPD meta-analysis contained data on prognostic factors at patient level. Therefore,

subgroup analyses based on the information for the individual patient and statistical tests for modification of results by patient and study characteristics could be analyzed across almost 14000 patients. Another advantage is the harmonized definition and analysis of different survival endpoints. I.e. we differentiated on study mortality and overall survival, which included the longest follow-up available. While overall survival aims to detect long-term effects, confounders occurring after the end of active study phase cannot be excluded. I.e. control patients may start ESA treatment, progression of the underlying malignancy may dominate the course of disease and follow-up might be less rigorous leading to losses to follow-up; all of these factors may dilute the overall effect. Indeed, the overall survival estimates in our analyses were lower compared to the on study mortality estimates. For the latter we restricted follow-up to the study phase when patients were under close and active observation and control of both ESA medication and events. Thus, on study mortality presents the most reliable information with respect to unconfounded assessment of the effects of ESAs during treatment period. This clear definition of separate endpoints at different periods under observation distinguishes our IPD meta-analysis from literature based meta-analyses, which must rely on the results as reported in the literature. However, survival is often not reported or reported incompletely. For example, in the reports identified for the 51 published studies analyzed here, five studies did not report any survival data, 19 reported on study mortality, 14 overall survival and only 13 reported both endpoints; two studies were unpublished. Given the paucity of published data previous literature-based meta-analyses ([Bohlius 2006](#); [Bennett 2008](#); [Seidenfeld 2006](#)) combined on study mortality and overall survival data into one analysis, which led to an underestimation of the effect size of ESAs on mortality.

Previous analyses hypothesized that poor study designs may have produced biased results. In particular, some argued that baseline imbalances favoring the control groups might partially explain the increased mortality ([Henke 2003](#); [Leyland-Jones 2003](#); [Smith 2008](#)). Our analysis found no evidence that imbalances at baseline in prognostic factors influenced the overall results. However, baseline imbalances for prognostic factors not included in the present analysis cannot be excluded. For the analysis of on study mortality in chemotherapy we observed that studies with adequate reporting of concealment of allocation reported worse effect estimates compared to studies with inadequate reporting of allocation procedures. In general, studies with adequate reporting of allocation concealment are considered to indicate studies of higher quality. Patients who were censored at a given point were often followed for only four weeks after the last drug application but not until the end of the planned treatment duration.

Epo receptors have been identified on the cell surface of numerous cancer entities. Consequently, endogenously produced or exogenously administered erythropoietins may stimulate proliferation of cancer cells expressing these receptors ([Arcasoy 2003](#); [Arcasoy 2005](#); [Dagnon 2005](#); [McBroom 2005](#); [Leo 2006](#)). However, controversy about the functionality of these receptors in tumor tissues remains ([Jelkmann 2008](#); [Sinclair 2008](#)). Data on Epo receptor status of tumor tissues were not systematically collected in the included trials and were therefore not available for the present study.

It was also hypothesized that the increase in hemoglobin levels associated with ESAs, particularly to beyond 15 g/dL, might impair

tumor control. Radiobiological data suggest that tumor hypoxia is associated with an increased resistance to radiation induced tumor cell kill due to lower production of cytotoxic free radicals (Vaupel 2001). Thus, tumor hypoxia caused either by anemia or excessively high hemoglobin levels and increased viscous resistance may result in worse treatment outcomes (Vaupel 2002). Similarly, it was argued, that high hemoglobin levels might increase the risk for fatal thromboembolic and cardiovascular events. Trials directly comparing different Hb targets in patients with renal impairment found increased mortality in patients treated to higher Hb targets (13.5 g/dL versus 11.3 g/dL) who had received higher ESA dosages (mean 11215 units per week versus 6276 IU per week) (Singh 2006; Besarab 1998). Of note, ESA dosages applied in cancer patients are on average three to four times higher than the high ESA doses reported in the study by Singh et al. We found no robust evidence for an interaction between ESA treatment hemoglobin ceilings, planned ESA dosages and mortality. However, our analysis was based on indirect comparisons only.

Other hypotheses relate to the effects of erythropoietins on the vascular system and tumor tissues. There is increasing evidence that ESAs might influence the vascular system including hematocrit-independent hypertension, increased endothelin production and stimulation of endothelial and vascular smooth muscle cell proliferation which may contribute to an increased risk of thromboembolic and cardiovascular events independent of Hb levels (Vaziri 1999; Fisher 2003; Stohlawetz 2000; Wun 2003). Intriguingly, in our analysis patients with a history of thromboembolic events were less likely to die when receiving ESAs compared to patients without a history of thromboembolic events. One potential explanation for the observed effect is the possibility that patients with a history of thromboembolic events may have received better anticoagulation precautions during cancer therapy and this measure may have protected against the thrombogenic effects of ESAs. This is in line with a finding from a randomized trial in critically ill patients indicating that patients receiving heparin were less likely to develop thromboembolic events when receiving ESAs compared to patients not receiving heparin (Corwin 2007). However, for 31% of our entire study population history of thromboembolic events was not reported; thus, a selection bias cannot be excluded. In conclusion, the evidence reported here is too weak to establish a robust association between history of thromboembolic events and effects of ESA on mortality during study in cancer patients. There was some evidence that women were at increased risk to die when receiving ESAs compared to men. This effect modification was only observed for overall survival in chemotherapy patients, however, for all other endpoints the risk for women to die when receiving ESAs ranged between HR 1.10 and HR 1.17, although not statistically significant. The observed estimates were attenuated when excluding patients with breast cancer and other cancers that occur in women or men only. Further investigation is needed to clarify this observation.

We also observed a modifying effect of baseline Hct on mortality during active study phase and long-term follow-up. Patients with low hematocrit at baseline (< 23.5%) were more likely to die when receiving ESAs compared to patients with higher hematocrit values. This observed effect was robust when adjusting for other prognostic factors such as tumor stage and ECOG performance status. Similarly, patients with baseline Hb below 8 g/dL were at increased risk to die compared to others, although this effect was not statistically significant in any of the analyses. This observation

may indicate that low hematocrit values are a surrogate for poor risk patients and that these patients might be more vulnerable to harm from ESAs. However, data for 21% of patients were missing leaving uncertainty to the validity of this finding.

Patients receiving ESAs three times per week or more frequently were not at increased risk to die compared to patients who received ESAs only once per week. This was observed for on study mortality analyses but not for the overall survival analyses. However, the data did not show a dose response relationship and the observed effect was confounded by other study design aspects such as planned dose of ESA, year of study conduct and primary endpoint of the study. The effect was not observed for the overall survival analysis.

Of particular interest is the possibility that ESAs have less potential harm in patients receiving chemotherapy compared to patients receiving radiochemotherapy, radiotherapy or no anticancer treatment. Mortality was increased in patients from chemotherapy trials by 10% (HR 1.10, 95% CI 0.98 to 1.24). From a statistical point of view the estimated increase in mortality from the chemotherapy trials is compatible with that obtained from other treatment group (including radiochemotherapy, radiotherapy, none and other, $p=0.42$ for difference). From a clinical point of view, patients not receiving myelosuppressive anticancer treatment might be more likely to experience higher hemoglobin levels leading to thromboembolic events and impaired tumor control, as discussed above. However, in the present analysis we found little evidence to support this notion.

AUTHORS' CONCLUSIONS

Implications for practice

In conclusion, this large scale individual patient data meta-analysis found that ESAs increase mortality in cancer patients, and such an increase is also likely in patients receiving chemotherapy. Most randomized studies and previous meta-analyses have shown that ESAs increase hemoglobin levels, decrease the need for red blood cell transfusions and spare some patients from transfusions (Seidenfeld 2001; Bohlius 2005). A recent meta-analysis also suggested that ESAs may effectively reduce fatigue (Minton 2008). In clinical practice the increased risks of death and thromboembolic events (Bohlius 2006; Bennett 2008) must be balanced against the possible benefits of ESAs on quality of life, taking into account the clinical circumstances and preferences of the individual patient.

Implications for research

More data are needed on ESAs effect on quality of life and an individual patient data meta-analysis project similar to this will be needed to address this question.

Further research is also needed to clarify mechanisms and pathways of ESAs effects at the cellular and molecular levels for both potential tumor growth stimulation and thrombogenic effects of ESAs.

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* Indicates the major publication for the study

CHARACTERISTICS OF STUDIES
Characteristics of included studies [ordered by study ID]
Aapro 2008

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 463, breast cancer (M1); concomitant treatment: chemotherapy
Interventions	drug = Epoetin beta dose = 30000 IU sc weekly hb-target = 13-15 d/dL planned ESA duration = 24 weeks
Outcomes	Primary: overall survival; secondary: progression free survival, tumor response rate, QoL
Notes	study number = 97413

Risk of bias

Aapro 2008 (Continued)

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Abels 1993

Methods	randomized controlled trial, placebo-controlled	
Participants	n = 124, hematological malignancies, genitourinary, gastrointestinal, other cancer; no anticancer therapy	
Interventions	drug = Epoetin alpha dose = 100 IU/kg sc TIW hb-target = not reported planned ESA duration = 8 weeks	
Outcomes	Primary: transfusion, Hct; secondary: QoL, safety	
Notes	study number = 98906	

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer-generated
Allocation concealment?	Unclear risk	each patient was assigned a random identification number and was assigned to a treatment group by a computerized randomization schedule

Boogaerts 2003

Methods	randomized controlled trial, not placebo-controlled	
Participants	n = 259, multiple myeloma, Non-Hodgkin lymphoma, chronic lymphocytic leukemia, Hodgkin disease, ovarian, bone, gastrointestinal, respiratory, other cancer; concomitant treatment: chemotherapy	
Interventions	drug = Epoetin beta dose = 150 IU/kg sc TIW hb-target = 12-14 g/dL planned ESA duration = 12 weeks	
Outcomes	Primary: QoL; secondary: direct and indirect costs	
Notes	study number = 36158	

Boogaerts 2003 (Continued)

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Case 1993

Methods	randomized controlled trial, placebo-controlled
Participants	n = 157, hematological malignancies, breast, lung, gynecological, gastrointestinal, other cancer; concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 150 IU/kg sc TIW hb-target = Hct 38%-40% planned ESA duration = 12 weeks
Outcomes	Transfusion, Hct, QoL, safety
Notes	study number = 34917

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer-generated
Allocation concealment?	Unclear risk	description is unclear

Cazzola 1995

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 143, multiple myeloma, Non-Hodgkin lymphoma; concomitant treatment: chemotherapy
Interventions	drug = Epoetin beta dose = a: 1000 IU sc 7x/week, b: 2000 IU sc 7x/week; c: 5000 IU sc 7x/week; d: 10000 IU sc 7x/week hb-target = 11-13 g/dL (MM), 11-15 g/dL (NHL) planned ESA duration = 8 weeks
Outcomes	Primary: Hb response; secondary: Hb, Hct, reticulocytes, iron, ferritin, safety
Notes	study number = 37653

Cazzola 1995 (Continued)

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	randomization list
Allocation concealment?	Low risk	central randomization

CC2574-P-174

Methods	randomized controlled trial, placebo-controlled
Participants	n = 45, chronic lymphocytic leukemia (any stage); concomitant therapy: other
Interventions	drug = Epoetin alpha dose = 150 IU/kg sc TIW hb-target = Hct 38%-40% planned ESA duration = 12 weeks
Outcomes	Primary: Hct; secondary: Hb, transfusion, QoL, safety
Notes	study number = 60584

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer generated
Allocation concealment?	Unclear risk	no description

Chang 2005

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 354, breast cancer (stage I-IV); concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 40000 IU sc weekly hb-target = 12-14 g/dL planned ESA duration = during chemotherapy
Outcomes	Primary: QoL; secondary: maintain Hb above 12 g/dL, tumor response, overall survival
Notes	study number = 99137

Chang 2005 (Continued)

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Charu 2007

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 287, lymphoma, breast, lung, gastrointestinal, genitourinary, gynecologic, other cancer; no anti-cancer therapy
Interventions	drug = Darbepoetin alpha dose = 3.0 µg/kg sc Q2W hb-target = 13-14 g/dL (women), 13-15 g/dL (men) planned ESA duration = 12 weeks
Outcomes	Primary: hospitalization days; secondary: costs, QoL, transfusion, Hb, safety
Notes	study number = 53081

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Dammacco 2001

Methods	randomized controlled trial, placebo-controlled
Participants	n = 145, multiple myeloma; concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 150 IU/kg sc TIW hb-target = 12-14 g/dL planned ESA duration = 12 weeks
Outcomes	Primary: transfusion; secondary: Hb, Hct, reticulocytes, serum erythropoietin levels, QoL
Notes	study number = 11220

Dammacco 2001 (Continued)

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	randomization schedule prepared by RWJPRI
Allocation concealment?	Unclear risk	two randomization lists (patients previously transfused or not), when patient enters the study the next number was to be assigned

Debus 2006

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 385, non-small cell lung cancer (stage III, primarily inoperable); concomitant treatment: radiochemotherapy
Interventions	drug = Epoetin alpha dose = 40000 IU sc weekly hb-target = 12-14 g/dL, in 11/2003 reduced to 12-13 g/dL planned ESA duration = during chemotherapy and radiotherapy
Outcomes	Primary: 2-year-survival rate; secondary: tumor response, QoL, tolerance to epoetin alpha, Hb change, transfusion, safety
Notes	study number = 83322

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	randomization code provided by OrthoBiothech
Allocation concealment?	Unclear risk	assigned envelopes, sequentially numbered, but it is unclear whether they were sealed and opaque

EPO-GBR-7

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 300, head and neck cancer (stage I-IV); concomitant treatment: radiotherapy
Interventions	drug = Epoetin alpha dose = if Hb < 12.5 10000 IU sc TIW; if Hb > 12.5 4000 IU sc TIW hb-target = 12.5-15 g/dL planned ESA duration = during radiotherapy

EPO-GBR-7 (Continued)

Outcomes	Primary: local disease free survival; secondary: overall survival, QoL, safety
Notes	study number = 81645

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	central randomization schedule stratified by the study site was generated by the sponsor
Allocation concealment?	Unclear risk	no description

EPO-GER-20

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 93, small cell lung cancer (extensive stage); concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 10000 IU sc TIW hb-target = 12-14 g/dL planned ESA duration = during chemotherapy
Outcomes	Primary: rate of patients with anemia; secondary: QoL, tolerability of ESA, transfusion, effectiveness of chemotherapy
Notes	study number = 31678

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	Patients were assigned with a randomization code provided by Janssen-Cilag
Allocation concealment?	Unclear risk	assigned envelopes, sequentially numbered, but it is unclear whether they were sealed and opaque

EPO-INT-1

Methods	randomized controlled trial, placebo-controlled
Participants	n = 246, ovarian cancer (stage I-IV); concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = a: 150 IU/kg sc TIW; b: 300 IU/kg sc TIW hb-target = 12.5 to 14 g/dL

EPO-INT-1 (Continued)

planned ESA duration = during chemotherapy

Outcomes	Primary: transfusion; secondary: Hb change, Hct, QoL
Notes	study number = 53915

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Unclear risk	no description

EPO-INT-3

Methods	randomized controlled trial, placebo-controlled
Participants	n = 200, breast, Non-Hodgkin lymphoma, multiple myeloma, ovarian, small cell lung cancer, other cancer; concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 150 IU/kg sc TIW hb-target = 12-14 g/dL (women), 14-16 g/dL (men) planned ESA duration = 12 weeks
Outcomes	Primary: Transfusion; secondary: Hb, QoL
Notes	study number = 36274

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	according to randomization schedule prepared by RWJPRI
Allocation concealment?	Low risk	central randomization

Gordon 2006

Methods	randomized controlled trial, placebo-controlled
Participants	n = 220, breast, non-myeloid hematological malignancies, gastrointestinal, genitourinary, lung, gynecological, other cancer (stage I-IV); no anticancer therapy
Interventions	drug = Darbepoetin alpha dose = 6.75 µg/kg sc Q4W hb-target = 12-13 g/dL

Erythropoietin or Darbepoetin for patients with cancer - meta-analysis based on individual patient data (Review)

Gordon 2006 (Continued)

planned ESA duration = 16 weeks

Outcomes	Primary: Hb response; secondary: transfusion, Hb change, QoL, safety
Notes	study number = 65772

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	randomization list will be centrally generated by Amgen
Allocation concealment?	Low risk	central randomization

Goss 2005

Methods	randomized controlled trial, placebo-controlled
Participants	n = 104, small cell lung cancer (limited disease); concomitant treatment: radiochemotherapy
Interventions	drug = Epoetin alpha dose = 40000 IU sc weekly hb-target = 14-16 g/dL, in 10/2002 reduced to 13-14 g/dL planned ESA duration = during chemotherapy and radiotherapy
Outcomes	Disease progression free survival, tumor response, overall survival, local disease progression, Hb, transfusion, QoL
Notes	study number = 55703

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer generated
Allocation concealment?	Low risk	central randomization

Grote 2005

Methods	randomized controlled trial, placebo-controlled
Participants	n = 224, small cell lung cancer (limited and extensive disease); concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 150 IU/kg sc TIW hb-target = 14-16 g/dL

Grote 2005 (Continued)

planned ESA duration = during chemotherapy

Outcomes	Primary: assess possible stimulatory effects of ESA on solid tumor growth, tumor response; secondary: overall survival, Hb, transfusion, safety
Notes	study number = 73807

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer-generated
Allocation concealment?	Unclear risk	description is unclear

Hedenus 2003

Methods	randomized controlled trial, placebo-controlled
Participants	n = 349, Hodgkin disease, Non-Hodgkin lymphoma, multiple myeloma, chronic lymphocytic leukemia, Waldenstrom 's disease; concomitant treatment: chemotherapy
Interventions	drug = Darbepoetin alpha dose = 2.25 µg/kg sc weekly hb-target = 13-14 g/dL (women), 13-15 g/dL (men) planned ESA duration = 12 weeks
Outcomes	Primary: Hb response; secondary: transfusion, Hb change, QoL, safety
Notes	study number = 63455

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	based on a schedule specified by Amgen before the start of the study
Allocation concealment?	Low risk	central randomization

Henke 2003

Methods	randomized controlled trial, placebo-controlled
Participants	n = 351, head and neck cancer (advanced, stage III, IV); concomitant treatment: radiotherapy
Interventions	drug = Epoetin beta dose = 300 IU/kg sc TIW hb-target = 12-14 g/dL (women), 13-15 g/dL (men)

Erythropoietin or Darbepoetin for patients with cancer - meta-analysis based on individual patient data (Review)

Henke 2003 (Continued)

planned ESA duration = during radiotherapy

Outcomes	Primary: efficacy of radiotherapy, measured as local progression free survival; secondary: survival, progression free survival, Hb, safety, tolerability
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Notes	study number = 58106
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Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	Each center had numbered packages per stratum, once randomized the lowest number had to be assigned. There was a randomization list only the statistics center had access to. In addition, there were sealed envelopes for emergencies.
Allocation concealment?	Low risk	coded drug packs of identical appearance

Henry 1995

Methods	randomized controlled trial, placebo-controlled
Participants	n = 132, lung, gynecological, gastrointestinal, hematological malignancies, other cancer; concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 150 IU/kg sc TIW hb-target = Hct 38%-40% planned ESA duration = 12 weeks
Outcomes	Primary: Hct, transfusion; secondary: correction of anemia, response, QoL, safety
Notes	study number = 70332

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer generated
Allocation concealment?	Unclear risk	Medication boxes were used, but without identical appearance

Huddart 2002

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 95, lung, gynecological, genitourinary, other cancer; concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha

Huddart 2002 (Continued)

dose = 10000 IU sc TIW
 hb-target = 12-14 g/dL
 planned ESA duration = during chemotherapy

Outcomes	Hb response, reticulocyte, survival, QoL, safety
Notes	study number = 88443

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Unclear risk	no description

Kotasek 2002

Methods	randomized controlled trial, placebo-controlled
Participants	n = 161, lung, breast, gastrointestinal, genitourinary, gynecological, other cancer (stage I-IV); concomitant treatment: chemotherapy
Interventions	drug = Darbepoetin alpha dose = a: 9 µg/kg sc Q4W, b: 12 µg/kg sc Q4W, c: 15 µg/kg sc Q4W, d: 18 µg/kg sc Q4W hb-target = 13-14 g/dL (women), 13-15 g/dL (men) planned ESA duration = 12 weeks
Outcomes	Primary: safety; secondary: determine effective dose, effect of ESA, QoL feasibility
Notes	study number = 26117

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Kotasek 2003

Methods	randomized controlled trial, placebo-controlled
Participants	n = 259, breast, gynecological, gastrointestinal, lung, genitourinary, other cancer (stage I-IV, most patients advanced); concomitant treatment: chemotherapy
Interventions	drug = Darbepoetin alpha

Erythropoietin or Darbepoetin for patients with cancer - meta-analysis based on individual patient data (Review)

Kotasek 2003 (Continued)

dose = a: 4.5 µg/kg sc Q3W, b: 6.75 µg/kg sc Q3W, c: 9 µg/kg sc Q3W, d: 12 µg/kg sc Q3W, e: 13.5 µg/kg sc Q3W, f: 15 µg/kg sc Q3W

hb-target = 13-14 g/dL (women), 13-15 g/dL (men)

planned ESA duration = 12 weeks

Outcomes	Primary: safety; secondary: determine effective dose, effect of ESA, QoL feasibility
Notes	study number = 35466

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Leyland-Jones 2003

Methods	randomized controlled trial, placebo-controlled
Participants	n = 939, breast cancer (stage IV, M1); concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 40000 IU sc weekly hb-target = 12-14 g/dL planned ESA duration = 52 weeks
Outcomes	Primary: overall survival; secondary: Hb, transfusion, tumor control, QoL, time to progression
Notes	study number = 17100

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer-generated
Allocation concealment?	Low risk	central randomization

Littlewood 2001

Methods	randomized controlled trial, placebo-controlled
Participants	n = 375, breast, Non-Hodgkin lymphoma, multiple myeloma, Hodgkin disease, chronic lymphocytic leukemia, gastrointestinal, other cancer; concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha

Erythropoietin or Darbepoetin for patients with cancer - meta-analysis based on individual patient data (Review)

Littlewood 2001 (Continued)

dose = 150 IU/kg sc TIW
 hb-target = 12-15 g/dL
 planned ESA duration = during chemotherapy

Outcomes Primary: transfusion; secondary: Hb, Hct, reticulocytes, predictors for response, QoL, after protocol amendment also survival

Notes study number = 17123

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer-generated randomization schedule prepared by RWJPRI
Allocation concealment?	Low risk	coded drug packs of identical appearance

Machtay 2007

Methods randomized controlled trial, not placebo-controlled

Participants n = 148, head and neck cancer (stage I-IV); concomitant treatment: radiotherapy

Interventions drug = Epoetin alpha
 dose = 40000 IU sc weekly
 hb-target = 12.5-14 g/dL (women), 13.5-16 g/dL (men)
 planned ESA duration = 8 weeks

Outcomes Primary: local regional control tumor response; secondary: overall survival, patterns of failure, local-regional progression-free survival, Hb, toxicity, QoL

Notes study number = 87660

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Milroy 2003

Methods randomized controlled trial, not placebo-controlled

Participants n = 424, non-small cell lung cancer (stage IIIb or IV, advanced); concomitant treatment: chemotherapy

Interventions drug = Epoetin alpha

Erythropoietin or Darbepoetin for patients with cancer - meta-analysis based on individual patient data (Review)

Milroy 2003 (Continued)

dose = if body weight > 45 kg 10000 IU sc TIW, if body weight < 45 kg 5000 IU sc TIW

hb-target = 12.5-14 g/dL (women), 13.5-15 g/dL (men)

planned ESA duration = during chemotherapy

Outcomes	Primary: QoL; secondary: Hb, tumor response, survival, transfusion
Notes	study number = 67954

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Moebus 2007

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 643, breast cancer (high risk, stage II/IIIA; M0); concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 150 IU/kg sc TIW hb-target = 13-14 g/dL planned ESA duration = during chemotherapy
Outcomes	Primary: transfusion, Hb; secondary: recurrence free survival, overall survival, relapse, QoL
Notes	study number = 22515

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer generated
Allocation concealment?	Low risk	central randomization

O'Shaughnessy 2005

Methods	randomized controlled trial, placebo-controlled
Participants	n = 100, breast cancer (stage I, II, IIIB); concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 40000 IU sc weekly

Erythropoietin or Darbepoetin for patients with cancer - meta-analysis based on individual patient data (Review)

O'Shaugnessy 2005 *(Continued)*

hb-target = 13-15 g/dL

planned ESA duration = during chemotherapy

Outcomes	Primary: cognitive function, fatigue; secondary: QoL
Notes	study number = 40730

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer generated
Allocation concealment?	Low risk	coded drug packs of identical appearance

OBE/EPO-INT-03

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 72, multiple myeloma; concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 40000 IU sc weekly hb-target = 12-13 g/dL planned ESA duration = during chemotherapy
Outcomes	Primary: Hb change; secondary: QoL, Hb response, transfusion, safety
Notes	study number = 92503

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Oberhoff 1998

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 227, ovarian, breast, lung, genitourinary, gastrointestinal, other cancer; concomitant treatment: chemotherapy
Interventions	drug = Epoetin beta dose = 5000 IU sc 7x per week

Oberhoff 1998 (Continued)

hb-target = 11-14 g/dL
 planned ESA duration = 12 weeks

Outcomes	Primary: transfusion ; secondary: Hb response, safety
Notes	study number = 45434

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Osterborg 1996

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 148, multiple myeloma, Non-Hodgkin lymphoma, chronic lymphocytic lymphoma; concomitant treatment: chemotherapy
Interventions	drug = Epoetin beta dose = a: 10000 IU sc 7x/week, b: titration hb-target = 10-14 g/dL (women), 10-13 g/dL (men) planned ESA duration = 24 weeks
Outcomes	Primary: transfusion; secondary: safety, Hb
Notes	study number = 43680

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Osterborg 2002

Methods	randomized controlled trial, placebo-controlled
Participants	n = 349, multiple myeloma, Non-Hodgkin lymphoma, chronic lymphocytic lymphoma; concomitant treatment: chemotherapy
Interventions	drug = Epoetin beta dose = 150 IU/kg sc TIW

Osterborg 2002 (Continued)

hb-target = 13-14 g/dL

planned ESA duration = 16 weeks

Outcomes	Primary: transfusion free survival; secondary: Hb response, time to response, number of blood transfusions, QoL, safety
Notes	study number = 77914

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	randomization program
Allocation concealment?	Low risk	central randomization

Pirker 2008

Methods	randomized controlled trial, placebo-controlled
Participants	n = 600, small cell lung cancer (untreated, extensive stage); concomitant treatment: chemotherapy
Interventions	drug = Darbeoetin alpha dose = 300 µg sc weekly for weeks 1-4 then 300 µg Q3W starting week 5 onwards hb-target = 13-14 g/dL planned ESA duration = 19 weeks
Outcomes	Primary: Hb change, survival; secondary: QoL, progression-free-survival, tumor response, time to progression, transfusion
Notes	study number = 89335

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Unclear risk	central randomization

Pronzato 2002

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 223, breast cancer (stage I-IV); concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = if body weight > 45 kg 10000 IU sc TIW, if < 45 kg 5000 IU sc TIW

Pronzato 2002 (Continued)

hb-target = 12-14 g/dL
planned ESA duration = during chemotherapy

Outcomes	Primary: QoL; secondary: Hb change, tumor response
Notes	study number = 22233

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Quirt 1996

Methods	randomized controlled trial, placebo-controlled
Participants	n = 56, lung, gynecological, hematological malignancies, other cancer; concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 150 IU/kg sc TIW hb-target = 12.5-14 g/dL planned ESA duration = 16 weeks
Outcomes	Primary: transfusion; secondary: QoL, costs from societal perspective, tumor response
Notes	study number = 80214

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Unclear risk	no description

Ray-Coquard 2006

Methods	randomized controlled trial,
Participants	n = 218, breast, sarcoma, lung, ovarian, other solid cancer and hematological malignancies; concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha

Ray-Coquard 2006 *(Continued)*

dose = if body weight < 45 kg 10000 IU sc 2x/week, if body weight 45 kg to < 89 kg 10000 IU sc TIW, if body weight > 89 kg 10000 IU sc 4x/week

hb-target = 12-14 g/dL

planned ESA duration = 12 weeks

Outcomes	Primary: transfusion dependent anemia; secondary: QoL, Hb response predictors, Hb, toxicity, survival, costs
Notes	study number = 37491

Razzouk 2006

Methods	randomized controlled trial, placebo-controlled
Participants	n = 126, solid tumors, Hodgkin disease, Non-Hodgkin lymphoma (patients excluded from the present meta-analysis), acute lymphocytic leukemia (patients excluded from the present meta-analysis); concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 600 IU/kg iv weekly hb-target = 13-15 g/dL (age > 12 years), 13-14 g/dL (age <12 years) planned ESA duration = 16 weeks
Outcomes	Primary: QoL; secondary: Hb, transfusion
Notes	study number = 80515

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer generated
Allocation concealment?	Low risk	central randomization and coded drug packs of identical appearance

Rose 1994

Methods	randomized controlled trial, placebo-controlled
Participants	n = 221, chronic lymphocytic leukemia (stage III, IV); concomitant therapy: other
Interventions	drug = Epoetin alpha dose = 150 IU/kg sc TIW hb-target = Hct 38%-40% planned ESA duration = 12 weeks

Rose 1994 (Continued)

Outcomes	Primary: Hct; secondary: transfusion, QoL, safety
Notes	study number = 98358

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer-generated
Allocation concealment?	Unclear risk	no description

Savonije 2005

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 315, non-small cell lung cancer, gastrointestinal, gynecological, colorectal, small cell lung cancer, other cancer; concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = 10000 IU sc TIW hb-target = 13-14 g/dL planned ESA duration = during chemotherapy
Outcomes	Primary: transfusion; secondary: Hb, tumor response, QoL, survival
Notes	study number = 70724

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	randomization center generates a list of subject numbers and randomly allocate numbers to the two treatment groups using a block size of six
Allocation concealment?	Low risk	central randomization

Smith 2008

Methods	randomized controlled trial, placebo-controlled
Participants	n = 989, lung, hematological malignancies, breast, gastrointestinal, genitourinary, other cancer (stage III-IV); no anticancer therapy
Interventions	drug = Darbepoetin alpha dose = 6.75 µg/kg sc Q4W hb-target = 12-13 g/dL

Smith 2008 (Continued)

planned ESA duration = 16 weeks

Outcomes	Primary: transfusion; secondary: Hb, QoL, safety
Notes	study number = 81215

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	based on a schedule specified by Amgen prior to the start of the study
Allocation concealment?	Low risk	central randomization

Strauss 2008

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 74, cervical cancer (stage IIB-IVA); concomitant treatment: radiochemotherapy
Interventions	drug = Epoetin beta dose = 150 IU/kg sc TIW hb-target = 14-15 g/dL planned ESA duration = 12 weeks
Outcomes	Primary: tumor control failures; secondary: progression-free survival, overall response rate, relapses/metastases, overall survival, Hb change, QoL, safety
Notes	study number = 70404

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	patient randomization number will be generated by Roche
Allocation concealment?	Unclear risk	patient randomization numbers are to be allocated sequentially in the order in which the patients are enrolled

Taylor 2005

Methods	randomized controlled trial, placebo-controlled
Participants	n = 391, non-myeloid hematological malignancies, breast, lung, gastrointestinal, genitourinary, gynecological, other cancer (stage I-IV); concomitant treatment: chemotherapy
Interventions	drug = Darbepoetin alpha dose = 300 µg sc Q3W

Taylor 2005 (Continued)

hb-target = 12-13 g/dL

planned ESA duration = 15 weeks

Outcomes	Primary: transfusion; secondary: Hb target achieved, number of transfusions, safety, QoL
Notes	study number = 37476

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Ten Bokkel Huinink 1998

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 120, ovarian cancer (stage II-IV); concomitant treatment: chemotherapy
Interventions	drug = Epoetin beta dose = a: 150 IU/kg sc TIW, b: 300 IU/kg sc TIW hb-target = 14-15 g/dL planned ESA duration = during chemotherapy
Outcomes	Primary: transfusion; secondary: Hb, reticulocytes, Hct, safety
Notes	study number = 47852

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Thatcher 1999

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 130, small cell lung cancer; concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = a: 150 IU/kg sc TIW, b: 300 IU/kg sc TIW hb-target = 13-15 g/dL

Thatcher 1999 (Continued)

planned ESA duration = 26 weeks

Outcomes	Efficacy, safety, QoL
Notes	study number = 65529

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	upon study entry each patient was assigned a sequential identification number which had been randomly assigned to chemotherapy with or without ESA, blocks of 6, each investigator had to treat at least 6 patients, but preferably 12 patients
Allocation concealment?	Unclear risk	see randomization

Thomas 2002

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 130, breast, gastrointestinal, gynecological, other cancer; concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = if body weight > 45 kg 10000 IU sc TIW, if body weight < 45 kg 5000 IU sc TIW hb-target = 12-14 g/dL planned ESA duration = 12 weeks
Outcomes	Primary: Hb response; secondary: QoL, tumor response, survival, safety
Notes	study number = 84090

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Thomas 2008

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 114, cervical cancer (stage IIB - IV A, M0); concomitant treatment: radiochemotherapy
Interventions	drug = Epoetin alpha dose = 40000 IU sc weekly hb-target = 13-14 g/dL

Erythropoietin or Darbepoetin for patients with cancer - meta-analysis based on individual patient data (Review)

Thomas 2008 (Continued)

planned ESA duration = during chemotherapy and radiotherapy

Outcomes	Primary: progression-free survival; secondary: overall survival, local control, distant recurrences, thromboembolic events
Notes	study number = 21481

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Low risk	central randomization

Untch 2008

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 729, breast cancer (M0); concomitant treatment: chemotherapy
Interventions	drug = Darbepoetin alpha dose = 4.5 µg/kg sc Q2W hb-target = 13 g/dL planned ESA duration = during chemotherapy
Outcomes	Primary: relapse free survival time, overall survival; secondary: tumor control, safety and tolerability, transfusion, Hb level, QoL
Notes	study number = 66960

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	no description
Allocation concealment?	Unclear risk	description is unclear

Vadhan-Raj 2004

Methods	randomized controlled trial, placebo-controlled
Participants	n = 60, gastric or rectal cancer (stage I-III); concomitant treatment: radiochemotherapy
Interventions	drug = Epoetin alpha dose = 40000 IU sc weekly hb-target = 14-15 g/dL

Erythropoietin or Darbepoetin for patients with cancer - meta-analysis based on individual patient data (Review)

Vadhan-Raj 2004 (Continued)

planned ESA duration = 16 weeks

Outcomes	Primary: transfusions; secondary: maintain Hb levels, QoL, tumor response, safety
Notes	study number = 30540

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer generated
Allocation concealment?	Low risk	coded drug packs of identical appearance

Vansteenkiste 2002

Methods	randomized controlled trial, placebo-controlled
Participants	n = 320, small cell lung cancer (limited and extensive), and non-small lung cancer (stage I-IV); concomitant treatment: chemotherapy
Interventions	drug = Darbepoetin alpha dose = 2.25 mg/kg sc weekly hb-target = 13-14 g/dL (women), 13-15 g/dL (men) planned ESA duration = 12 weeks
Outcomes	Primary: transfusion; secondary: Hb response, Hb, transfusion timing and quantity, QoL
Notes	study number = 49684

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	based on a schedule specified by Amgen before the start of the study
Allocation concealment?	Low risk	central randomization

Wilkinson 2006

Methods	randomized controlled trial, not placebo-controlled
Participants	n = 182, ovarian cancer (stage I-IV); concomitant treatment: chemotherapy
Interventions	drug = Epoetin alpha dose = if body weight > 45 kg 10000 IU sc TIW, if < 45 kg 5000 IU sc TIW hb-target = 12-14 g/dL

Wilkinson 2006 (Continued)

planned ESA duration = during chemotherapy

Outcomes Primary: Hb response; secondary: QoL, transfusion, tumor response

Notes study number = 75688

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Unclear risk	a prospective randomization procedure will be employed
Allocation concealment?	Unclear risk	assigned envelopes, sealed, but it is unclear whether they were opaque and sequentially numbered

Witzig 2005

Methods randomized controlled trial, placebo-controlled

Participants n = 344, lung, breast, other cancer (active incurable advanced stage); concomitant treatment: chemotherapy

 Interventions drug = Epoetin alpha
 dose = 40000 IU sc weekly
 hb-target = 13-15 g/dL
 planned ESA duration = 16 weeks

Outcomes Primary: transfusion; secondary: Hb change, haemoglobin over time, predictors for response, incidence of nephrotoxicity, overall survival, tumor response, QoL

Notes study number = 36512

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer generated
Allocation concealment?	Low risk	central randomization and coded drug packs of identical appearance

Wright 2007

Methods randomized controlled trial, placebo-controlled

Participants n = 70, non-small lung cancer (advanced stage IIIA, B and IV, recurrent disease); no anticancer therapy

 Interventions drug = Epoetin alpha
 dose = 40000 IU sc weekly

Wright 2007 (Continued)

hb-target = 12-14 g/dL

planned ESA duration = 12 weeks

Outcomes	Primary: QoL; secondary: Hb, Hct, transfusion, safety
Notes	study number = 53572

Risk of bias

Bias	Authors' judgement	Support for judgement
Adequate sequence generation?	Low risk	computer generated
Allocation concealment?	Low risk	central randomization

Characteristics of excluded studies [ordered by study ID]

Study	Reason for exclusion
Abdelrazik 2007	ineligible patient characteristics (e.g. with MDS or SAA)
Alexopoulos 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Antonadou 2001	no access to the individual patient data
Aravantinos 2003	too small for inclusion
Auerbach 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Aziz 2001	too small for inclusion
Bamias 2003	no access to the individual patient data
Beggs 2003	too small for inclusion
Bessho 1997	ineligible patient characteristics (e.g. with MDS or SAA)
Bindi 2004	too small for inclusion
Blayney 2003	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Blohmer 2003	no access to the individual patient data
Candelaria 2005	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Canon 2006	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised

Study	Reason for exclusion
Carabantes 1999	too small for inclusion
Casadevall 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Cascinu 1994	no access to the individual patient data
Cazzola 2003	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Chan 1995	too small for inclusion
Charu 2007a	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Christodoulakis 2005	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Crawford 1997	too small for inclusion
Crawford 2003	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Crawford 2007	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Daneryd 1998	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Dannemann 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Del Mastro 1997	too small for inclusion
Dunphy 1999	too small for inclusion
Elsaid 2001	too small for inclusion
Freeman 2006	too small for inclusion
Garton 1995	too small for inclusion
Gebbia 1992	too small for inclusion
Glaspy 2002	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Glaspy 2003	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Glaspy 2005	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Glaspy 2006	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised

Study	Reason for exclusion
Glimelius 1998	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Glossmann 2003	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Granetto 2003	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Hedenus 2002	too small for inclusion
Hedenus 2007	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Hellström Lindberg 1998	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Henke 1999	too small for inclusion
Henry 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Henry 2006	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Henry 2007	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Henze 2002	ineligible patient characteristics (e.g. with MDS or SAA)
Hesketh 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Iconomou 2003	no access to the individual patient data
Italian 1998	ineligible patient characteristics (e.g. with MDS or SAA)
Janinis 2003	no access to the individual patient data
Jitnuyanont 2001	too small for inclusion
Johansson 2001	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Justice 2005	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Kettelhack 1998	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Kosmadakis 2003	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Kotasek 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised

Study	Reason for exclusion
Kotasek 2007	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Kunikane 2001	too small for inclusion
Kurz 1997	too small for inclusion
Mangiameli 2002	too small for inclusion
Marinaccio 2003	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Merlano 2001	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
MF4266	ineligible patient characteristics (e.g. with MDS or SAA)
Miller 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Morishima 2006	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Mystakidou 2005	no access to the individual patient data
Olsson 2002	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Overgaard 2007	no access to the individual patient data
Pierelli 1999	too small for inclusion
Policarpo 2007	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Porter 1996	too small for inclusion
Rau 1998	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Rearden 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Reed 2005	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Rosen 2003	too small for inclusion
Rosenzweig 2004	too small for inclusion
Rubio-Martinez 2003	too small for inclusion
Sakai 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised

Study	Reason for exclusion
Schwartzberg 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Schwartzberg 2005	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Schwartzberg 2007	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Scott 2002	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Senecal 2005	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Shi 2007	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Silvestris 1995	too small for inclusion
Smith 2003	too small for inclusion
Spicka 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Steensma 2006	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Stein 1991	ineligible patient characteristics (e.g. with MDS or SAA)
Straus 2006	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Sweeney 1998	too small for inclusion
Thompson 2000	ineligible patient characteristics (e.g. with MDS or SAA)
Throuvalas 2000	too small for inclusion
Tsukuda 1998	too small for inclusion
Varan 1999	too small for inclusion
Wagner 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Waltzman 2005	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Watanabe 2006	no access to the individual patient data
Welch 1995	too small for inclusion
Wurnig 1996	too small for inclusion

Study	Reason for exclusion
Yilmaz 2004	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Zagari 2003	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Zajda 2007	no access to the individual patient data
Zhang 2003	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised
Zhou 2006	ESAs were given in context with surgery, stem cell transplantation, compared different ESA dosages or ESA products (epoetin versus darbepoetin), or trials were not randomised

ADDITIONAL TABLES

Table 1. Missing or not reported data per variable, in order of percentage missing

	Missing in ESA arm	Missing in control arm
Total included	7634	6299
Sex	0	0
Age	6 (0.1%)	6 (0.1%)
Tumor type*	17 (0.2%)	25 (0.4%)
Region (country)	231 (3.0%)	170 (2.7%)
Hb at baseline	252 (3.3%)	274 (4.3%)
Cancer stage at study entry (free text entry)	761 (10.0%)	732 (11.6%)
Derived variable stage (metastatic/advanced versus not)	1036 (13.6%)	745 (11.8%)
Hct at baseline	1493 (19.6%)	1404 (22.3%)
Chemotherapy given during ESA study?	1501 (19.7%)	1252 (19.9%)
BMI baseline	1515 (19.8%)	973 (15.4%)
Documented history of cardiovascular event	1932 (25.3%)	1679 (26.7%)
Chemotherapy given before ESA study?	1965 (25.7%)	1736 (27.6%)
Baseline ECOG performance status**	2035 (26.7%)	1786 (28.4%)
Radiotherapy given during ESA study?	2097 (27.5%)	1766 (28.0%)
Documented history of thromboembolic events	2272 (29.8%)	2041(32.4%)

Table 1. Missing or not reported data per variable, in order of percentage missing (Continued)

Documented history of hypertension	2272 (29.8%)	2041 (32.4%)
Radiotherapy given before esa study?	2529 (33.1%)	2216 (35.2%)
Documented history of diabetes mellitus	3335 (43.7%)	2573 (40.8%)
Baseline serum epo (mu/ml)	4371 (57.3%)	3911 (62.1%)
Cancer treatment status at study entry	5366 (70.3%)	4613 (73.2%)
Cancer stage at study entry	6123 (80.2%)	5069 (80.5%)

*For an independent study we received tumor types based on French pathology terms. To date we have not transferred these data into the uniform coding system developed and used for the present study, the data of that study are coded as “other” for the time being.

**Baseline ECOG status: If other performance score systems such as Karnofsky scores were reported these were used for the analysis but are counted as missing for the present table.

Table 2. Hazard ratios for censoring and hazard ratios for on study mortality in selected studies

Study number	On study censoring ESA versus control HR (95% CI)*	On study mortality ESA versus control HR (95% CI)*
53081	0.47 (95% CI 0.35, 0.64)	0.89 (95% CI 0.19, 4.17)
21481	0.57 (95% CI 0.39, 0.84)	0.94 (95% CI 0.06, 15.01)
45434	0.34 (95% CI 0.25, 0.47)	0.62 (95% CI 0.25, 1.58)
70404	0.52 (95% CI 0.32, 0.83)	0 deaths
87660	0.57 (95% CI 0.40, 0.80)	1.58 (95% CI 0.38, 6.61)
34917	1.62 (95% CI 1.15, 2.28)	1.10 (95% CI 0.45, 2.72)
36158	1.47 (95% CI 1.14, 1.90)	1.02 (95% CI 0.42, 2.45)

* based on two-stage Cox random-effects meta-analysis

Table 3. Hazard ratios for censoring and hazard ratios for on study mortality in selected studies

Study number	On study censoring ESA versus control HR (95% CI)*	On study mortality ESA versus control HR (95% CI)*
17100	1.01 (95% CI 0.87, 1.16)	1.42 (95% CI 1.08, 1.86)
53572	0.89 (95% CI 0.37, 2.15)	1.68 (95% CI 0.95, 2.98)
67954	1.16 (95% CI 0.94, 1.44)	1.45 (95% CI 0.95, 2.21)
81215	1.00 (95% CI 0.87, 1.15)	1.37 (95% CI 1.05, 1.78)
97413	1.00 (95% CI 0.82, 1.22)	1.38 (95% CI 0.89, 2.13)

* based on two-stage Cox random-effects meta-analysis

Table 4. On study mortality for all cancer patients

Model	ESA versus control HR (95% CI)	P value*	I ²	P value**
Two-stage log-rank fixed effects model	1.17 (95% CI 1.06-1.30)	0.0025	0%	0.8735
Two-stage log-rank random effects model	1.17 (95% CI 1.06-1.30)	0.0025	0%	0.8735
Two-stage Cox fixed effects model	1.16 (95% CI 1.05-1.29)	0.0042	0%	0.9303
Two-stage Cox random effects model	1.16 (95% CI 1.05-1.29)	0.0042	0%	0.9303
Cox model stratified by study	1.17 (95% CI 1.06-1.30)	0.0025		0.6310

*LR test, ** for test of heterogeneity

Table 5. Bivariate analyses for on study mortality in all cancer patients

On study mortality for all cancer patients	N included	ESA versus control Unadjusted HR (95% CI)	ESA versus control Adjusted HR (95% CI)	P value LR-Test
Total	13933	1.17 (95% CI 1.06-1.30)	-	-
Hb at baseline (continuous)	13407	1.17 (95% CI 1.06-1.30)	1.18 (95% CI 1.07-1.31)	0.0000
Hb at baseline (categorical 1)	13407	1.17 (95% CI 1.06-1.30)	1.18 (95% CI 1.06-1.31)	0.0000
Hb at baseline (categorical 2)	13407	1.17 (95% CI 1.06-1.30)	1.18 (95% CI 1.07-1.31)	0.0000
Tumor (categorical 1)	13891	1.17 (95% CI 1.06-1.30)	1.17 (95% CI 1.06-1.30)	0.0000
Tumor (categorical 2)	13891	1.17 (95% CI 1.06-1.30)	1.16 (95% CI 1.05-1.29)	0.0000
Sex	13933	1.17 (95% CI 1.06-1.30)	1.16 (95% CI 1.05-1.29)	0.0000
Age (continuous)	13921	1.17 (95% CI 1.06-1.30)	1.17 (95% CI 1.06-1.30)	0.0007
Age (categorical)	13921	1.17 (95% CI 1.06-1.30)	1.18 (95% CI 1.06-1.30)	0.0160
Hct (continuous)	11036	1.18 (95% CI 1.06-1.31)	1.19 (95% CI 1.07-1.32)	0.0000
Hct (categorical)	11036	1.18 (95% CI 1.06-1.31)	1.19 (95% CI 1.07-1.33)	0.0000
Baseline serum EPO (cont.)	5651	1.11 (95% CI 0.95-1.29)	1.10 (95% CI 0.95-1.28)	0.1798
Baseline serum EPO (cat.)	5651	1.11 (95% CI 0.95-1.29)	1.10 (95% CI 0.95-1.28)	0.0006
ECOG (0 vs 1 vs 2 vs 3 vs 4)	10112	1.19 (95% CI 1.06-1.33)	1.17 (95% CI 1.05-1.32)	0.0000
ECOG (0,1,2 vs 3,4)	10225	1.18 (95% CI 1.06-1.33)	1.19 (95% CI 1.06-1.34)	0.0000
BMI (categorical)	11445	1.16 (95% CI 1.04-1.30)	1.17 (95% CI 1.04-1.31)	0.0000

Table 5. Bivariate analyses for on study mortality in all cancer patients (Continued)

History of thromboembolic events	9620	1.20 (95% CI 1.06-1.34)	1.19 (95% CI 1.06-1.34)	0.1105
History of cardiovascular events	10322	1.20 (95% CI 1.06-1.34)	1.19 (95% CI 1.06-1.34)	0.1002
History of hypertension	9620	1.20 (95% CI 1.06-1.34)	1.20 (95% CI 1.06-1.34)	0.8464
History of diabetes mellitus	8025	1.20 (95% CI 1.06-1.35)	1.20 (95% CI 1.06-1.35)	0.4497
Geographical region [region_cat]	13532	1.17 (95% CI 1.05-1.29)	1.16 (95% CI 1.05-1.29)	0.0001
Metastatic vs non-metastatic	12152	1.21 (95% CI 1.09-1.35)	1.21 (95% CI 1.08-1.35)	0.0000
Time from cancer diagnosis to randomization	4586	1.17 (95% CI 0.99-1.39)	1.18 (95% CI 1.00-1.40)	0.0000

Table 6. Multivariate analysis on study mortality in all cancer patients

On study mortality in all cancer patients	Model 1	Model 2	Model 3	Model 4
Patients included	n=13353	n=11636	n=10599	n=6547
	HR (95% CI)	HR (95% CI)	HR (95% CI)	HR (95% CI)
ESA vs control unadjusted*	1.17 (95% CI 1.06-1.30)	1.22 (95% CI 1.09-1.36)	1.16 (95% CI 1.03-1.30)	1.20 (95% CI 1.06-1.37)
ESA vs control adjusted**	1.17 (95% CI 1.06-1.30)	1.21 (95% CI 1.08-1.35)	1.16 (95% CI 1.03-1.30)	1.23 (95% CI 1.08-1.39)
Hb at baseline				
Hb < 8 g/dL	1	1	1	1
Hb 8-10 g/dL	0.70 (95% CI 0.58-0.85)	0.66 (95% CI 0.53-0.81)	0.69 (95% CI 0.57-0.85)	0.83 (95% CI 0.62-1.10)
Hb 10-12 g/dL	0.49 (95% CI 0.40-0.60)	0.46 (95% CI 0.37-0.57)	0.52 (95% CI 0.42-0.65)	0.71 (95% CI 0.51-0.98)
Hb 12-14 g/dL	0.33 (95% CI 0.26-0.42)	0.31 (95% CI 0.24-0.40)	0.38 (95% CI 0.29-0.49)	0.52 (95% CI 0.35-0.77)
Hb > 14 g/dL	0.28 (95% CI 0.20-0.39)	0.27 (95% CI 0.20-0.38)	0.33 (95% CI 0.23-0.46)	0.45 (95% CI 0.26-0.79)
Age at randomization				
18 - 35 yrs	0.90 (95% CI 0.55-1.46)	1.04 (95% CI 0.61-1.77)	0.88 (95% CI 0.51-1.54)	0.79 (95% CI 0.42-1.47)
35 - 45 yrs	1	1	1	1

Table 6. Multivariate analysis on study mortality in all cancer patients (Continued)

45 - 55 yrs	1.09 (95% CI 0.86-1.39)	1.08 (95% CI 0.84-1.40)	1.15 (95% CI 0.87-1.52)	1.03 (95% CI 0.77-1.37)
55 - 65 yrs	1.23 (95% CI 0.97-1.54)	1.25 (95% CI 0.98-1.60)	1.37 (95% CI 1.05-1.78)	1.19 (95% CI 0.90-1.57)
65 - 75 yrs	1.30 (95% CI 1.03-1.64)	1.28 (95% CI 0.99-1.64)	1.51 (95% CI 1.15-1.97)	1.33 (95% CI 1.00-1.77)
> 75 yrs	1.40 (95% CI 1.07-1.82)	1.46 (95% CI 1.09-1.94)	1.52 (95% CI 1.12-2.08)	1.22 (95% CI 0.87-1.71)
Sex				
Male	1	1	1	1
Female	0.80 (95% CI 0.70-0.91)	0.83 (95% CI 0.72-0.96)	0.83 (95% CI 0.72-0.96)	0.84 (95% CI 0.71-0.99)
Tumor category				
Hematological malignancies	1	1	1	1
Breast cancer	1.55 (95% CI 1.09-2.20)	1.39 (95% CI 0.88-2.19)	1.60 (95% CI 1.08-2.38)	1.72 (95% CI 1.12-2.64)
Head and neck cancer	2.29 (95% CI 1.24-4.22)	1.84 (95% CI 0.87-3.86)	1.69 (95% CI 0.83-3.44)	1.71 (95% CI 0.71-4.12)
Lung cancer	3.15 (95% CI 2.32-4.30)	2.61 (95% CI 1.74-3.91)	2.97 (95% CI 2.06-4.29)	3.49 (95% CI 2.35-5.18)
Gastrointestinal	2.82 (95% CI 2.05-3.88)	2.54 (95% CI 1.67-3.87)	2.59 (95% CI 1.79-3.77)	2.87 (95% CI 1.92-4.30)
Gynecological	1.47 (95% CI 0.98-2.19)	1.22 (95% CI 0.74-2.01)	1.69 (95% CI 1.08-2.64)	2.14 (95% CI 1.31-3.38)
Genitourinary	2.16 (95% CI 1.54-3.05)	1.97 (95% CI 1.28-3.03)	2.14 (95% CI 1.44-3.18)	2.48 (95% CI 1.63-3.79)
Other	2.85 (95% CI 1.99-4.07)	2.63 (95% CI 1.67-4.16)	2.76 (95% CI 1.82-4.18)	3.01 (95% CI 1.91-4.74)
Tumor stage				
Metastatic/advanced	-	1	-	-
Not Metastatic/advanced	-	0.47 (95% CI 0.37-0.59)	-	-
Region				
Northern America	-	-	1	1
Southern Europe	-	-	1.35 (95% CI 0.90-2.02)	1.33 (95% CI 0.87-2.04)

Table 6. Multivariate analysis on study mortality in all cancer patients (Continued)

Australia & New Zealand	-	-	1.18 (95% CI 0.75-1.86)	1.26 (95% CI 0.76-2.07)
Eastern Europe	-	-	1.66 (95% CI 1.19-2.31)	1.64 (95% CI 1.16-2.31)
Northern Europe	-	-	1.75 (95% CI 1.20-2.55)	1.94 (95% CI 1.31-2.88)
Western Europe	-	-	1.75 (95% CI 1.21-2.51)	1.84 (95% CI 1.25-2.70)
Other	-	-	1.38 (95% CI 0.74-2.58)	1.76 (95% CI 0.92-3.38)
BMI				
< 19 kg/m ²	-	-	1	1
19-25 kg/m ²	-	-	0.64 (95% CI 0.53-0.77)	0.65 (95% CI 0.53-0.80)
25-30 kg/m ²	-	-	0.51 (95% CI 0.41-0.62)	0.50 (95% CI 0.40-0.63)
> 30 kg/m ²	-	-	0.42 (95% CI 0.33-0.54)	0.44 (95% CI 0.34-0.58)
Hct at baseline				
Hct < 23.5%	-	-	-	1
Hct 23.5%-29.4%	-	-	-	0.68 (95% CI 0.46-1.01)
Hct 29.4%-35.3%	-	-	-	0.52 (95% CI 0.34-0.79)
Hct 35.3%-41.2%	-	-	-	0.49 (95% CI 0.30-0.79)
>Hct 41.2%	-	-	-	0.47 (95% CI 0.26-0.84)
Performance score				
ECOG 0, 1 or 2	-	-	-	1
ECOG 3 or 4	-	-	-	4.03 (95% CI 2.83-5.74)

*unadjusted based on the patients included in respective model, **adjusted for variables outlined in the columns

Table 7. Assessment of interaction for on study mortality in all cancer patients

On study mortality, all cancer patients	Patients included	P value for interaction*
Total included	13933	-
Patient level characteristics (subgroup analysis)		
Hb at baseline (continuous)	13407	0.8164
Hb at baseline (categorical 1)	13407	0.7479
Hb at baseline (categorical 2)	13407	0.7917

Table 7. Assessment of interaction for on study mortality in all cancer patients (Continued)

Tumor (categorical 1)	13891	0.1623
Tumor (categorical 2)	13891	0.4697
Sex	13933	0.8607
Age (continuous)	13921	0.8677
Age (categorical)	13921	0.5002
Hct (continuous)	11036	0.5656
Hct (categorical)	11036	0.0110
Baseline serum EPO (continuous)	5651	0.2139
Baseline serum EPO (categorical)	5651	0.5436
ECOG	10112	0.6324
ECOG (0,1,2 vs 3,4)	10225	0.5600
BMI (categorical)	11445	0.7246
History of thromboembolic events	9620	0.0605
History of cardiovascular events	10322	0.6227
History of hypertension	9620	0.7626
History of diabetes mellitus	8025	0.6962
Geographical region [region_cat]	13532	0.1707
Metastatic vs non-metastatic	12152	0.7588
Planned Hb ceiling (categorical 1)	13730	0.9777
Planned Hb ceiling (categorical 2)	13730	0.8840
Study level characteristics (subset analysis)		
Placebo controlled	13933	0.3780
Randomization (adequate vs unclear)	13933	0.9848
Allocation (adequate vs unclear)	13933	0.2347
Endpoint overall survival	13933	0.4074
Year of last patient randomized into study (categorical)	13933	0.2351
Source of data (company versus independent)	13933	0.1281
Patient population (chemotherapy, radiochemotherapy,	13933	0.4148

Table 7. Assessment of interaction for on study mortality in all cancer patients *(Continued)*
 radiotherapy, none, mixed)

Iron category	13933	0.4784
Planned ESA treatment duration (categorical)	13933	0.3338
Planned weekly ESA dosage (categorical)	13933	0.1227
Planned frequency of ESA administration (categorical)	13933	0.0274

*P value for interaction based on LR test, patients with missing data are excluded from LR test

Table 8. Assessment of selected interaction terms for on study mortality in all cancer patients, univariate and multivariate analyses

On study mortality all cancer patients	Pa-tients total		ESA arm				Control arm				Bivariate analysis ESR versus control			Multivariate analysis ESR versus control adjusted for age, sex, Hb, tumor type		
	N	n	N	%	n	N	%	HR	95% CI	p*	HR	95% CI	p*			
Hct at baseline, categorical																
< 23.5%	390	55	210	26%	24	180	13%	2.19	1.35-3.55		2.12	1.30-3.48				
23.5-29.4%	2788	199	1567	13%	191	1221	16%	0.96	0.78-1.77		0.96	0.79-1.18				
29.4-35.3%	4615	321	2692	12%	223	1923	12%	1.17	0.99-1.39	0.011	1.15	0.97-1.37	0.0191			
35.3-41.2%	2458	176	1258	14%	130	1200	11%	1.41	1.12-1.76		1.39	1.10-1.74				
> 41.2%	785	48	414	12%	40	371	11%	1.12	0.73-1.70		1.15	0.76-1.76				
<i>Missing / not reported</i>	2897	66	1493	4%	57	1404	4%	1.09	0.76-1.55	-	<i>omitted</i>		-			
History of thromboembolic events																
Yes	561	40	318	13%	42	243	17%	0.80	0.52-1.23		0.77	0.50-1.19	0.0440			
No	9059	637	5044	13%	474	4015	12%	1.23	1.09-1.39	0.060	1.22	1.08-1.38				
<i>Missing / not reported</i>	4313	188	2272	8%	149	2041	7%	1.09	0.87-1.35		<i>omitted</i>					
Planned frequency of ESA application																
Three times per week or more frequent	6131	311	3458	9%	238	2673	9%	1.01	0.85-1.20		1.01	0.85-1.21				
Once per week	3948	303	1972	15%	231	1976	12%	1.39	1.18-1.66	0.027	1.41	1.18-1.67	0.0369			
Every second week or less frequent	3036	180	1795	10%	122	1241	10%	1.25	0.99-1.57		1.19	0.94-1.50				
Other	818	71	409	17%	74	409	18%	0.93	0.67-1.29		0.96	0.69-1.32				

*P value from LR test for interaction. Missing data were excluded when testing for interaction.

Table 9. On study mortality for all cancer patients

Model	ESA versus control HR (95% CI)	P value*	I ²	P value**
Two-stage log-rank fixed effect model	1.10 (95% CI 0.98-1.24)	0.1212	0%	0.7152
Two-stage log-rank random effects model	1.10 (95% CI 0.98-1.24)	0.1212	0%	0.7152
Two-stage Cox fixed effect model	1.09 (95% CI 0.97-1.23)	0.1555	0%	0.8813
Two-stage Cox random effects model	1.09 (95% CI 0.97-1.23)	0.1555	0%	0.8813
Cox model stratified by study	1.10 (95% CI 0.98-1.24)	0.121		0.4643

*LR test, ** for test of heterogeneity

Table 10. Bivariate analysis for on study mortality in chemotherapy trials

On study mortality for chemotherapy patients	N includ- ed	ESA versus control Unadjusted HR (95% confidence interval)	ESA versus control Adjusted HR (95% confidence interval)	P value LR-Test*
Total	10441	1.10 (95% CI 0.98-1.24)	-	-
Hb at baseline (continuous)	9945	1.10 (95% CI 0.98-1.25)	1.12 (95% CI 0.99-1.26)	0.0000
Hb at baseline (categorical 1)	9945	1.10 (95% CI 0.98-1.25)	1.12 (95% CI 0.99-1.26)	0.0000
Hb at baseline (categorical 2)	9945	1.10 (95% CI 0.98-1.25)	1.12 (95% CI 0.99-1.26)	0.0000
Tumor (categorical 1)	10399	1.10 (95% CI 0.97-1.24)	1.10 (95% CI 0.97-1.24)	0.0049
Tumor (categorical 2)	10399	1.10 (95% CI 0.97-1.24)	1.10 (95% CI 0.97-1.24)	0.0000
Sex	10441	1.10 (95% CI 0.98-1.24)	1.10 (95% CI 0.97-1.24)	0.0000
Age (continuous)	10430	1.10 (95% CI 0.98-1.24)	1.10 (95% CI 0.98-1.24)	0.0000
Age (categorical)	10430	1.10 (95% CI 0.98-1.24)	1.10 (95% CI 0.98-1.24)	0.0002
Hct (continuous)	7849	1.11 (95% CI 0.98-1.26)	1.12 (95% CI 0.98-1.27)	0.0000
Hct (categorical)	7849	1.11 (95% CI 0.98-1.26)	1.12 (95% CI 0.98-1.27)	0.0000
Baseline serum EPO (con- tinuous)	3959	0.99 (95% CI 0.82-1.20)	0.99 (95% CI 0.82-1.19)	0.2936
Baseline serum EPO (cate- gorical)	3959	0.99 (95% CI 0.82-1.20)	0.98 (95% CI 0.81-1.19)	0.0651
ECOG (0 vs 1 vs 2 vs 3 vs 4)	8057	1.12 (95% CI 0.98-1.28)	1.11 (95% CI 0.97-1.27)	0.0000
ECOG (0,1,2 vs 3,4)	8057	1.12 (95% CI 0.98-1.28)	1.12 (95% CI 0.98-1.29)	0.0000

Table 10. Bivariate analysis for on study mortality in chemotherapy trials (Continued)

BMI (categorical)	8882	1.08 (95% CI 0.94-1.23)	1.09 (95% CI 0.95-1.24)	0.0000
History of thromboembolic events	6667	1.11 (95% CI 0.96-1.28)	1.11 (95% CI 0.96-1.28)	0.0658
History of cardiovascular events	7369	1.11 (95% CI 0.96-1.28)	1.10 (95% CI 0.96-1.27)	0.0394
History of hypertension	6667	1.11 (95% CI 0.96-1.28)	1.11 (95% CI 0.96-1.28)	0.7143
History of diabetes mellitus	5579	1.09 (95% CI 0.94-1.26)	1.09 (95% CI 0.94-1.27)	0.0802
Geographical region [region_cat]	10053	1.09 (95% CI 0.97-1.23)	1.09 (95% CI 0.97-1.24)	0.2767
Metastatic vs non-metastatic	8956	1.16 (95% CI 1.02-1.32)	1.15 (95% CI 1.01-1.31)	0.0000
Time from cancer diagnosis to randomization	3114	1.06 (95% CI 0.85-1.31)	1.06 (95% CI 0.85-1.32)	0.6775

*This test compares the adjusted with the unadjusted model. It takes into account the entire model, not only the overall hazard ratio.

Table 11. Multivariate models for on study mortality in chemotherapy trials

On study mortality chemotherapy trials	Model 1	Model 2	Model 3	Model 4
Patients included	n=9892	n=8469	n=8030	n=5109
	HR (95% CI)	HR (95% CI)	HR (95% CI)	HR (95% CI)
ESA vs control, unadjusted	1.10 (95% CI 0.98-1.25)	1.16 (95% CI 1.02-1.33)	1.07 (95% CI 0.94-1.23)	1.13 (95% CI 0.97-1.31)
ESA vs control, adjusted	1.12 (95% CI 0.99-1.26)	1.17 (95% CI 1.02-1.33)	1.08 (95% CI 0.95-1.24)	1.16 (95% CI 0.99-1.34)
Hb at baseline				
Hb < 8 g/dL	1	1	1	1
Hb 8 - 10 g/dL	0.79 (95% CI 0.62-1.01)	0.73 (95% CI 0.55-0.96)	0.76 (95% CI 0.58-1.00)	0.91 (95% CI 0.61-1.34)
Hb 10 - 12 g/dL	0.57 (95% CI 0.44-0.74)	0.53 (95% CI 0.39-0.70)	0.61 (95% CI 0.46-0.82)	0.76 (95% CI 0.50-1.14)
Hb 12 - 14 g/dL	0.36 (95% CI 0.27-0.49)	0.33 (95% CI 0.24-0.46)	0.42 (95% CI 0.30-0.57)	0.52 (95% CI 0.33-0.82)
Hb > 14 g/dL	0.32 (95% CI 0.22-0.47)	0.30 (95% CI 0.20-0.46)	0.36 (95% CI 0.24-0.54)	0.45 (95% CI 0.25-0.83)
Age at randomization				

Table 11. Multivariate models for on study mortality in chemotherapy trials (Continued)

18 - 35 yrs	0.92 (95% CI 0.54-1.57)	1.12 (95% CI 0.62-2.01)	0.94 (95% CI 0.51-1.74)	0.77 (95% CI 0.38-1.50)
35 - 45 yrs	1	1	1	1
45 - 55 yrs	1.16 (95% CI 0.88-1.51)	1.16 (95% CI 0.86-1.55)	1.24 (95% CI 0.91-1.70)	1.08 (95% CI 0.78-1.63)
55 - 65 yrs	1.27 (95% CI 0.98-1.64)	1.31 (95% CI 0.99-1.74)	1.46 (95% CI 1.07-1.97)	1.19 (95% CI 0.87-1.63)
65 - 75 yrs	1.51 (95% CI 1.16-1.97)	1.52 (95% CI 1.14-2.02)	1.74 (95% CI 1.28-2.38)	1.52 (95% CI 1.10-2.09)
> 75 yrs	1.69 (95% CI 1.24-2.31)	1.93 (95% CI 1.37-2.71)	1.95 (95% CI 1.35-2.81)	1.61 (95% CI 1.08-2.40)
Sex				
Male	1	1	1	1
Female	0.78 (95% CI 0.66-0.92)	0.82 (95% CI 0.69-0.99)	0.84 (95% CI 0.70-1.00)	0.87 (95% CI 0.71-1.07)
Tumor category				
Hematological malign.	1	1	1	1
Breast cancer	1.36 (95% CI 0.88-2.09)	1.12 (95% CI 0.60-2.11)	1.32 (95% CI 0.81-2.17)	1.38 (95% CI 0.78-2.43)
Head and neck cancer	2.23 (95% CI 0.68-7.32)	1.59 (95% CI 0.21-12.12)	1.47 (95% CI 0.20-11.07)	-
Lung cancer	2.78 (95% CI 1.83-4.20)	2.06 (95% CI 1.11-3.80)	2.86 (95% CI 1.70-4.80)	3.83 (95% CI 2.15-6.80)
Gastrointestinal	2.54 (95% CI 1.68-3.83)	1.90 (95% CI 1.02-3.52)	2.45 (95% CI 1.50-4.01)	2.79 (95% CI 1.60-4.85)
Gynecological	1.07 (95% CI 0.64-1.80)	0.61 (95% CI 0.29-1.29)	1.38 (95% CI 0.76-2.50)	2.20 (95% CI 1.10-4.40)
Genitourinary	1.34 (95% CI 0.73-2.44)	0.97 (95% CI 0.42-2.26)	1.06 (95% CI 0.47-2.42)	1.19 (95% CI 0.41-3.43)
Other	2.65 (95% CI 1.68-4.17)	2.11 (95% CI 1.10-4.02)	2.69 (95% CI 1.56-4.62)	3.17 (95% CI 1.71-5.87)
Tumor stage				
Metastatic/advanced	-	1	-	-
Not metastatic/advanced	-	0.38 (95% CI 0.28-0.52)	-	-
Region				

Table 11. Multivariate models for on study mortality in chemotherapy trials (Continued)

Northern America	-	-	1	1
Southern Europe	-	-	1.20 (95% CI 0.66-2.17)	1.21 (95% CI 0.64-2.31)
Australia & New Zealand	-	-	1.00 (95% CI 0.55-1.81)	1.06 (95% CI 0.52-2.14)
Eastern Europe	-	-	1.33 (95% CI 0.76-2.30)	1.32 (95% CI 0.73-2.40)
Northern Europe	-	-	1.25 (95% CI 0.70-2.26)	1.43 (95% CI 0.75-2.74)
Western Europe	-	-	1.50 (95% CI 0.86-2.63)	1.61 (95% CI 0.88-2.95)
Other	-	-	1.14 (95% CI 0.53-2.43)	1.46 (95% CI 0.66-3.26)
BMI				
< 19 kg/m ²	-	-	1	1
19-25 kg/m ²	-	-	0.73 (95% CI 0.57-0.92)	0.76 (95% CI 0.58-1.00)
25-30 kg/m ²	-	-	0.61 (95% CI 0.47-0.78)	0.63 (95% CI 0.48-0.85)
> 30 kg/m ²	-	-	0.50 (95% CI 0.37-0.68)	0.54 (95% CI 0.39-0.76)
Hct at baseline				
Hct 0-23.5%	-	-	-	1
Hct 23.5%-29.4%	-	-	-	0.71 (95% CI 0.37-1.35)
Hct 29.4%-35.3%	-	-	-	0.61 (95% CI 0.32-1.16)
Hct 35.3%-41.2%	-	-	-	0.60 (95% CI 0.31-1.19)
>Hct 41.2%	-	-	-	0.58 (95% CI 0.27-1.24)
Performance score				
ECOG 0, 1 or 2	-	-	-	1
ECOG 3 or 4	-	-	-	3.08 (95% CI 1.99-4.77)

Table 12. Assessment of interaction for on study mortality in chemotherapy trials

On study mortality, chemotherapy patients	N included	P value for interaction*
Total unadjusted (Cox model)	10441 (100%)	-
Patient level characteristics		
Hb at baseline (continuous)	9945	0.8689
Hb at baseline (categorical 1)	9945	0.9035

Table 12. Assessment of interaction for on study mortality in chemotherapy trials (Continued)

Hb at baseline (categorical 2)	9945	0.9881
Tumor (categorical 1)	10399	0.1846
Tumor (categorical 2)	10399	0.1509
Sex	10441	0.1395
Age (continuous)	10430	0.5684
Age (categorical)	10430	0.3442
Hct (continuous)	7849	0.5722
Hct (categorical)	7849	0.2189
Baseline serum EPO (continuous)	3959	0.9051
Baseline serum EPO (categorical)	3959	0.2047
ECOG	8057	0.5776
ECOG (0,1,2 vs 3,4)	8057	0.9970
BMI (categorical)	8882	0.6333
History of thromboembolic events	6667	0.1421
History of cardiovascular events	7369	0.9285
History of hypertension	6667	0.6079
History of diabetes mellitus	5579	0.7429
Geographical region [region_cat]	10053	0.3543
Metastatic vs non-metastatic	8956	0.6083
Planned Hb ceiling (categorical 1)	10362	0.2834
Planned Hb ceiling (categorical 2)	10362	0.3788
Study level characteristics		
Placebo controlled	10441	0.5349
Randomization (adequate vs unclear)	10441	0.8789
Allocation (adequate vs unclear)	10441	0.0722
Endpoint overall survival	10441	0.1117
Year of last patient randomized into study (categorical)	10441	0.1568
Source of data (company versus independent)	10441	0.1842

Table 12. Assessment of interaction for on study mortality in chemotherapy trials (Continued)

Iron category	10441	0.5201
Planned ESA treatment duration (categorical)	10441	0.2020
Planned weekly ESA dosage (categorical)	10441	0.2940
Planned frequency ESA administration (categorical)	10441	0.0544

*P value for interaction based on LR test, patients with missing data are excluded from LR test

Table 13. Interaction for on study mortality in chemotherapy trials

On study mortality chemotherapy patients	Bivariate ESA versus control			Multivariate ESA versus control		
Interaction term	ESA* variable			ESA* variable		
Model adjusted for	-			age, sex, Hb, tumor type		
Patients included	n = 10441			n = 9892		
	HR	95% CI	P value LR test	HR	95% CI	P value LR test
Study level characteristics						
Planned frequency of ESA application						
Three times per week or more frequent	0.97	0.81-1.17	0.0544	0.97	0.81-1.18	0.0453
Once per week	1.35	1.12-1.64		1.38	1.14-1.68	
Every second week or less frequent	0.92	0.51-1.68		0.92	0.51-1.68	
Other	0.93	0.67-1.29		0.95	0.67-1.32	
Overall, unadjusted	1.10	0.98-1.24	-	1.10	0.98-1.25	-
Concealment of allocation						
Adequate	1.15	1.01-1.30	0.0722	1.17	1.02-1.33	0.0608
Unclear	0.81	0.57-1.16		0.81	0.57-1.16	
Overall, unadjusted	1.10	0.98-1.24	-	1.10	0.98-1.25	-

Table 14. Overall survival for all cancer patients

Model	ESA versus control HR (95% CI)	P value*	I ²	P value**
Two-stage log-rank fixed effect model	1.06 (95% CI 1.00-1.12)	0.0464	7.1%	0.3288

Table 14. Overall survival for all cancer patients (Continued)

Two-stage log-rank random effects model	1.06 (95% CI 1.00-1.13)	0.0611	7.1%	0.3288
Two-stage Cox fixed effect model	1.06 (95% CI 1.00-1.12)	0.0561	0%	0.6129
Two-stage Cox random effects model	1.06 (95% CI 1.00-1.12)	0.0561	0%	0.6129
Cox model stratified by study	1.06 (95% CI 1.00-1.12)	0.0462		0.2072

*LR test, ** for test of heterogeneity

Table 15. Bivariate analysis for overall survival in all cancer patients

Overall survival all cancer patients	Patients included	ESA versus control Unadjusted hazard ratio (95% CI)	ESA versus control Adjusted hazard ratio (95% CI)	P value LR-Test*
Total	13933	1.06 (95% CI 1.00-1.12)	-	-
Hb at baseline (continuous)	13407	1.06 (95% CI 1.00-1.12)	1.06 (95% CI 1.00-1.12)	0.0000
Hb at baseline (categorical 1)	13407	1.06 (95% CI 1.00-1.12)	1.06 (95% CI 1.00-1.12)	0.0000
Hb at baseline (categorical 2)	13407	1.06 (95% CI 1.00-1.12)	1.06 (95% CI 1.00-1.13)	0.0000
Tumor (categorical 1)	13891	1.06 (95% CI 1.00-1.12)	1.06 (95% CI 1.00-1.12)	0.0000
Tumor (categorical 2)	13891	1.06 (95% CI 1.00-1.12)	1.05 (95% CI 1.00-1.11)	0.0000
Sex	13933	1.06 (95% CI 1.00-1.12)	1.06 (95% CI 1.00-1.12)	0.0000
Age (continuous)	13921	1.06 (95% CI 1.00-1.12)	1.06 (95% CI 1.00-1.12)	0.0000
Age (categorical)	13921	1.06 (95% CI 1.01-1.12)	1.06 (95% CI 1.01-1.12)	0.0000
Hct (continuous)	11036	1.06 (95% CI 0.99-1.12)	1.06 (95% CI 1.00-1.13)	0.0000
Hct (categorical)	11036	1.06 (95% CI 0.99-1.12)	1.06 (95% CI 1.00-1.13)	0.0000
Baseline serum EPO (continuous)	5651	1.03 (95% CI 0.94-1.12)	1.03 (95% CI 0.94-1.12)	0.1678
Baseline serum EPO (categorical)	5651	1.03 (95% CI 0.94-1.12)	1.03 (95% CI 0.94-1.12)	0.0000
ECOG (0 vs 1 vs 2 vs 3 vs 4)	10112	1.08 (95% CI 1.01-1.15)	1.07 (95% CI 1.00-1.14)	0.0000
ECOG (0,1,2 vs 3,4)	10225	1.08 (95% CI 1.01-1.15)	1.08 (95% CI 1.01-1.16)	0.0000
BMI (categorical)	11445	1.05 (95% CI 0.99-1.12)	1.05 (95% CI 0.99-1.12)	0.0000
History of thromboembolic events	9620	1.05 (95% CI 0.98-1.12)	1.05 (95% CI 0.98-1.12)	0.0218
History of cardiovascular events	10322	1.05 (95% CI 0.99-1.13)	1.05 (95% CI 0.98-1.13)	0.0011

Table 15. Bivariate analysis for overall survival in all cancer patients (Continued)

History of hypertension	9620	1.05 (95% CI 0.98-1.12)	1.05 (95% CI 0.98-1.12)	0.2436
History of diabetes mellitus	8025	1.06 (95% CI 0.99-1.14)	1.06 (95% CI 0.98-1.14)	0.0577
Geographical region (categorical 1)	13532	1.05 (95% CI 1.00-1.12)	1.06 (95% CI 1.00-1.12)	0.0000
Metastatic vs non-metastatic	12152	1.06 (95% CI 1.00-1.13)	1.05 (95% CI 0.99-1.12)	0.0000
Time from cancer diagnosis to randomization	4586	1.06 (95% CI 0.97-1.17)	1.06 (95% CI 0.97-1.16)	0.0000

*The LR test compares the adjusted with the unadjusted model. It takes into account the entire model, not only the overall hazard ratio.

Table 16. Multivariate analyses for overall survival in all cancer patients

Overall survival all cancer patients	Model 1	Model 2	Model 3	Model 4
Patients included	n=13353	n=11636	n=10599	n=6547
	HR (95% CI)	HR (95% CI)	HR (95% CI)	HR (95% CI)
ESA vs ctrl unadjusted*	1.06 (95% CI 1.00-1.12)	1.06 (95% CI 1.00-1.13)	1.04 (95% CI 0.98-1.11)	1.07 (95% CI 0.99-1.15)
ESA vs ctrl adjusted**	1.06 (95% CI 1.00-1.12)	1.05 (95% CI 1.00-1.12)	1.04 (95% CI 0.98-1.11)	1.09 (95% CI 1.01-1.17)
Hb at baseline				
Hb < 8 g/dL	1	1	1	1
Hb 8-10 g/dL	0.77 (95% CI 0.68-0.87)	0.72 (95% CI 0.63-0.83)	0.78 (95% CI 0.68-0.90)	0.86 (95% CI 0.70-1.04)
Hb 10-12 g/dL	0.60 (95% CI 0.52-0.68)	0.56 (95% CI 0.48-0.64)	0.62 (95% CI 0.54-0.71)	0.74 (95% CI 0.60-0.92)
Hb 12-14 g/dL	0.48 (95% CI 0.41-0.56)	0.45 (95% CI 0.38-0.53)	0.52 (95% CI 0.44-0.61)	0.71 (95% CI 0.55-0.93)
Hb > 14 g/dL	0.40 (95% CI 0.33-0.48)	0.39 (95% CI 0.32-0.47)	0.44 (95% CI 0.36-0.54)	0.69 (95% CI 0.48-0.99)
Age at randomization				
18 - 35 yrs	0.82 (95% CI 0.62-1.07)	0.91 (95% CI 0.68-1.22)	0.84 (95% CI 0.62-1.13)	0.65 (95% CI 0.42-1.00)
35 - 45 yrs	1	1	1	1
45 - 55 yrs	1.06 (95% CI 0.93-1.21)	1.05 (95% CI 0.91-1.20)	1.10 (95% CI 0.95-1.28)	1.16 (95% CI 0.96-1.40)

Table 16. Multivariate analyses for overall survival in all cancer patients (Continued)

55 - 65 yrs	1.13 (95% CI 1.00-1.28)	1.15 (95% CI 1.01-1.31)	1.25 (95% CI 1.08-1.44)	1.32 (95% CI 1.09-1.58)
65 - 75 yrs	1.23 (95% CI 1.08-1.39)	1.22 (95% CI 1.07-1.40)	1.34 (95% CI 1.16-1.55)	1.34 (95% CI 1.11-1.62)
> 75 yrs	1.32 (95% CI 1.14-1.53)	1.40 (95% CI 1.19-1.63)	1.39 (95% CI 1.17-1.65)	1.31 (95% CI 1.06-1.63)
Sex				
Male	1	1	1	1
Female	0.79 (95% CI 0.73-0.84)	0.81 (95% CI 0.75-0.88)	0.80 (95% CI 0.74-0.86)	0.77 (95% CI 0.70-0.84)
Tumor category				
Hematological malign.	1	1	1	1
Breast cancer	1.91 (95% CI 1.54-2.37)	1.57 (95% CI 1.15-2.13)	1.93 (95% CI 1.51-2.46)	2.05 (95% CI 1.59-2.65)
Head and neck cancer	2.57 (95% CI 1.87-3.53)	2.31 (95% CI 1.56-3.41)	2.56 (95% CI 1.79-3.65)	3.38 (95% CI 1.96-5.83)
Lung cancer	4.06 (95% CI 3.31-4.99)	3.06 (95% CI 2.30-4.07)	3.79 (95% CI 2.96-4.86)	3.98 (95% CI 3.07-5.16)
Gastrointestinal	3.08 (95% CI 2.49-3.82)	2.90 (95% CI 2.15-3.90)	3.11 (95% CI 2.42-4.01)	3.27 (95% CI 2.51-4.26)
Gynecological	2.19 (95% CI 1.70-2.82)	1.67 (95% CI 1.20-2.32)	2.33 (95% CI 1.74-3.12)	2.86 (95% CI 2.11-3.88)
Genitourinary	2.76 (95% CI 2.17-3.50)	2.36 (95% CI 1.72-3.22)	2.69 (95% CI 2.04-3.55)	2.90 (95% CI 2.18-3.87)
Other	3.21 (95% CI 2.55-4.04)	2.94 (95% CI 2.15-4.01)	3.24 (95% CI 2.48-4.24)	3.35 (95% CI 2.52-4.47)
Tumor stage				
Metastatic or advanced	-	1	-	-
Not metastatic/advanced	-	0.51 (95% CI 0.46-0.57)	-	-
Region				
Northern America	-	-	1	1
Southern Europe	-	-	1.33 (95% CI 1.06-1.68)	1.27 (95% CI 1.00-1.61)
Australia & New Zealand	-	-	0.97 (95% CI 0.72-1.31)	0.97 (95% CI 0.71-1.32)
Eastern Europe	-	-	1.50 (95% CI 1.23-1.82)	1.50 (95% CI 1.22-1.83)

Table 16. Multivariate analyses for overall survival in all cancer patients (Continued)

Northern Europe	-	-	1.59 (95% CI 1.29-1.97)	1.61 (95% CI 1.29-2.01)
Western Europe	-	-	1.47 (95% CI 1.19-1.82)	1.47 (95% CI 1.18-1.83)
Other	-	-	1.23 (95% CI 0.85-1.77)	1.51 (95% CI 0.96-2.37)
BMI				
< 19 kg/m ²	-	-	1	1
19-25 kg/m ²	-	-	0.79 (95% CI 0.70-0.88)	0.82 (95% CI 0.71-0.94)
25-30 kg/m ²	-	-	0.69 (95% CI 0.61-0.77)	0.70 (95% CI 0.60-0.81)
> 30 kg/m ²	-	-	0.61 (95% CI 0.53-0.71)	0.61 (95% CI 0.51-0.72)
Hct at baseline				
Hct <23.5%	-	-	-	1
Hct 23.5%-29.4%	-	-	-	0.84 (95% CI 0.63-1.12)
Hct 29.4%-35.3%	-	-	-	0.71 (95% CI 0.53-0.96)
Hct 35.3%-41.2%	-	-	-	0.61 (95% CI 0.44-0.85)
>Hct 41.2%	-	-	-	0.48 (95% CI 0.32-0.72)
Performance score				
ECOG 0, 1 or 2	-	-	-	1

*unadjusted HR based on the number of patients included in the respective model

**HR adjusted for the variables outlined in the respective columns

Table 17. Assessment of interaction, overall survival in all cancer patients

Overall survival, all cancer patients	Patients included	P value for interaction
Total	13933	
Patient level characteristics		
Hb at baseline (continuous)	13407	0.7547
Hb at baseline (categorical 1)	13407	0.6326
Hb at baseline (categorical 2)	13407	0.8292
Tumor (categorical 1)	13891	0.2315
Tumor (categorical 2)	13891	0.2122
Sex plus	13933	0.1480

Table 17. Assessment of interaction, overall survival in all cancer patients (Continued)

Age (continuous)	13921	0.3758
Age (categorical)	13921	0.2610
Hct (continuous)	11036	0.8998
Hct (categorical)	11036	0.0330
Baseline serum EPO (continuous)	5651	0.1424
Baseline serum EPO (categorical)	5651	0.8116
ECOG	10112	0.4115
ECOG (0,1,2 vs 3,4)	10225	0.4980
BMI (categorical)	11445	0.7189
History of thromboembolic events	9620	0.8964
History of cardiovascular events	10322	0.6886
History of hypertension	9620	0.5700
History of diabetes mellitus	8025	0.9435
Geographical region [region_cat]	13532	0.9000
Metastatic vs non-metastatic	12152	0.8573
Planned Hb ceiling (categorical 1)	13730	0.3973
Planned Hb ceiling (categorical 2)	13730	0.5976
Study level characteristics		
Placebo controlled	13933	0.2932
Randomization (adequate vs unclear)	13933	0.8042
Allocation (adequate vs unclear)	13933	0.4945
Endpoint overall survival	13933	0.3866
Designed for long term follow up (binary)	13933	0.6423
Year of last patient randomized into study (categorical)	13933	0.1285
Source of data (company versus independent)	13933	0.5736
Patient population (chemotherapy, radio-chemo-therapy, none, mixed)	13933	0.1133
Iron category	13933	0.4786
Planned ESA treatment duration (categorical)	13933	0.7393

Table 17. Assessment of interaction, overall survival in all cancer patients (Continued)

Planned weekly ESA dosage (categorical)	13933	0.8780
Planned frequency of ESA administration (categorical)	13933	0.0748

*P value for interaction based on LR test, patients with missing data are excluded from LR test

Table 18. Overall survival in all cancer patient trials, test for interaction, univariate and multivariate models

Overall survival in all cancer patients	Bivariate ESA versus control			Multivariate ESA versus control		
	Interaction term			Interaction term		
Adjusted for	ESA*variable			ESA*variable		
	HR	95% CI	P*	HR	95% CI	P*
Patient level characteristics						
Hct categorical	0.0330			0.1343		
Patients included	n = 11036			n = 10972		
< 23.5%	1.66	1.18-2.34		1.54	1.09-2.18	
23.5-29.4%	0.94	0.83-1.07		0.96	0.84-1.09	
29.4-35.3%	1.10	0.99-1.21		1.08	0.98-1.19	
35.3-41.2%	1.07	0.95-1.21		1.07	0.95-1.21	
> 41.2%	1.02	0.82-1.26		1.04	0.84-1.29	
Missing	1.08	0.93-1.24	-	omitted	omitted	-
Overall, unadjusted	1.06	0.99-1.12	-	1.06	0.99-1.12	-
Study level characteristics						
Planned frequency of ESA application	0.0748			0.1949		
Patients included	n = 13933			n = 13353		
Three times per week or more frequent	1.07	0.98-1.18		1.07	0.97-1.15	
Once per week	1.06	0.97-1.17		1.08	0.87-1.18	
Every second week or less frequent	1.20	1.02-1.40		1.14	0.97-1.34	
Other	0.90	0.77-1.05	-	0.91	0.78-1.06	-
Overall, unadjusted	1.06	1.00-1.39	-	1.06	1.00-1.30	-

*P value LR test

Table 19. Overall survival for chemotherapy trials

Model	ESA versus control HR (95% CI)	P value*	I ²	P value**
Two-stage log-rank fixed-effect model	1.04 (95% CI 0.97-1.11)	0.2634	5.3%	0.3775
Two-stage log-rank random-effect model	1.04 (95% CI 0.97-1.12)	0.2774	5.3%	0.3775
Two-stage Cox fixed-effect model	1.04 (95% CI 0.97-1.11)	0.3081	0%	0.6828
Two-stage Cox random-effects model	1.04 (95% CI 0.97-1.11)	0.3081	0%	0.6828
Cox model stratified by study	1.04 (95% CI 0.97-1.11)	0.263	-	0.2359

*LR test, ** for test of heterogeneity

Table 20. Bivariate analysis for overall survival in chemotherapy trials

Overall survival for chemotherapy patients	Patients included	ESA versus control Unadjusted hazard ratio (95% CI)	ESA versus control Adjusted hazard ratio (95% CI)	P value LR-Test*
Total	10441	1.04 (95% CI 0.97-1.11)	-	-
Hb at baseline (continuous)	9945	1.04 (95% CI 0.97-1.11)	1.05 (95% CI 0.98-1.12)	0.0000
Hb at baseline (categorical 1)	9945	1.04 (95% CI 0.97-1.11)	1.05 (95% CI 0.98-1.12)	0.0000
Hb at baseline (categorical 2)	9945	1.04 (95% CI 0.97-1.11)	1.05 (95% CI 0.98-1.12)	0.0000
Tumor (categorical 1)	10399	1.04 (95% CI 0.97-1.11)	1.04 (95% CI 0.97-1.11)	0.0000
Tumor (categorical 2)	10399	1.04 (95% CI 0.97-1.11)	1.03 (95% CI 0.97-1.11)	0.0000
Sex	10441	1.04 (95% CI 0.97-1.11)	1.04 (95% CI 0.97-1.11)	0.0000
Age (continuous)	10430	1.04 (95% CI 0.97-1.11)	1.04 (95% CI 0.97-1.11)	0.0000
Age (categorical)	10430	1.04 (95% CI 0.97-1.11)	1.04 (95% CI 0.97-1.11)	0.0000
Hct (continuous)	7849	1.03 (95% CI 0.96-1.11)	1.04 (95% CI 0.97-1.12)	0.0000
Hct (categorical)	7849	1.03 (95% CI 0.96-1.11)	1.04 (95% CI 0.97-1.12)	0.0000
Baseline serum EPO (con- tinuous)	3959	0.97 (95% CI 0.88-1.07)	0.97 (95% CI 0.88-1.07)	0.1538
Baseline serum EPO (cate- gorical)	3959	0.97 (95% CI 0.88-1.07)	0.97 (95% CI 0.88-1.07)	0.0000
ECOG (0 vs 1 vs 2 vs 3 vs 4)	8057	1.04 (95% CI 0.97-1.12)	1.04 (95% CI 0.96-1.12)	0.0000

Table 20. Bivariate analysis for overall survival in chemotherapy trials (Continued)

ECOG (0,1,2 vs 3,4)	8057	1.04 (95% CI 0.97-1.12)	1.04 (95% CI 0.97-1.12)	0.0000
BMI (categorical)	8882	1.02 (95% CI 0.95-1.10)	1.03 (95% CI 0.95-1.10)	0.0000
History of thromboembolic events	6667	1.04 (95% CI 0.95-1.13)	1.03 (95% CI 0.95-1.12)	0.0194
History of cardiovascular events	7369	1.04 (95% CI 0.96-1.13)	1.04 (95% CI 0.96-1.13)	0.0033
History of hypertension	6667	1.04 (95% CI 0.95-1.13)	1.03 (95% CI 0.95-1.12)	0.5565
History of diabetes mellitus	5579	1.04 (95% CI 0.95-1.14)	1.05 (95% CI 0.95-1.15)	0.0253
Geographical region [region_cat]	10053	1.03 (95% CI 0.97-1.10)	1.03 (95% CI 0.97-1.11)	0.1689
Metastatic vs non-metastatic	8956	1.06 (95% CI 0.98-1.13)	1.04 (95% CI 0.97-1.12)	0.0000
Time from cancer diagnosis to randomization	3114	1.01 (95% CI 0.91-1.13)	1.01 (95% CI 0.91-1.13)	0.7895

*This test compares the adjusted with the unadjusted model. It takes into account the entire model, not only the overall hazard ratio.

Table 21. Multivariate models for overall survival in chemotherapy trials

Overall survival, chemotherapy trials	Model 1	Model 2	Model 3	Model 4
Patients included	n=9892	n=8469	n=8030	n=5109
	HR (95% CI)	HR (95% CI)	HR (95% CI)	HR (95% CI)
ESA vs ctrl unadjusted*	1.04 (95% CI 0.97-1.11)	1.05 (95% CI 0.98-1.13)	1.01 (95% CI 0.94-1.09)	1.02 (95% CI 0.94-1.11)
ESA vs ctrl adjusted**	1.05 (95% CI 0.98-1.12)	1.05 (95% CI 0.98-1.13)	1.02 (95% CI 0.94-1.10)	1.04 (95% CI 0.96-1.14)
Hb at baseline				
Hb < 8 g/dL	1	1	1	1
Hb 8-10 g/dL	0.85 (95% CI 0.73-0.99)	0.79 (95% CI 0.66-0.94)	0.87 (95% CI 0.74-1.03)	0.97 (95% CI 0.76-1.23)
Hb 10-12 g/dL	0.67 (95% CI 0.57-0.79)	0.62 (95% CI 0.51-0.74)	0.72 (95% CI 0.60-0.86)	0.83 (95% CI 0.64-1.07)
Hb 12-14 g/dL	0.53 (95% CI 0.44-0.64)	0.49 (95% CI 0.40-0.60)	0.59 (95% CI 0.48-0.72)	0.78 (95% CI 0.58-1.05)
Hb > 14 g/dL	0.44 (95% CI 0.35-0.56)	0.41 (95% CI 0.32-0.53)	0.48 (95% CI 0.37-0.62)	0.76 (95% CI 0.51-1.13)

Table 21. Multivariate models for overall survival in chemotherapy trials (Continued)

Age at randomization				
18 - 35 yrs	0.79 (95% CI 0.59-1.07)	0.89 (95% CI 0.65-1.22)	0.83 (95% CI 0.59-1.15)	0.56 (95% CI 0.34-0.91)
35 - 45 yrs	1	1	1	1
45 - 55 yrs	1.09 (95% CI 0.94-1.26)	1.07 (95% CI 0.91-1.25)	1.15 (95% CI 0.97-1.36)	1.19 (95% CI 0.96-1.46)
55 - 65 yrs	1.16 (95% CI 1.01-1.33)	1.18 (95% CI 1.02-1.37)	1.32 (95% CI 1.11-1.55)	1.33 (95% CI 1.08-1.63)
65 - 75 yrs	1.29 (95% CI 1.11-1.49)	1.28 (95% CI 1.09-1.49)	1.42 (95% CI 1.20-1.69)	1.41 (95% CI 1.14-1.73)
> 75 ys	1.43 (95% CI 1.20-1.70)	1.54 (95% CI 1.27-1.86)	1.57 (95% CI 1.28-1.93)	1.56 (95% CI 1.22-2.00)
Sex				
Male	1	1	1	1
Female	0.74 (95% CI 0.68-0.80)	0.76 (95% CI 0.69-0.83)	0.76 (95% CI 0.70-0.83)	0.76 (95% CI 0.68-0.84)
Tumor category				
Hematological malignancies	1	1	1	1
Breast cancer	1.88 (95% CI 1.46-2.42)	1.50 (95% CI 0.98-2.29)	1.87 (95% CI 1.39-2.51)	1.98 (95% CI 1.44-2.71)
Head and neck cancer	1.84 (95% CI 0.80-4.23)	1.71 (95% CI 0.23-12.7)	2.03 (95% CI 0.28-14.97)	0.00
Lung cancer	4.15 (95% CI 3.19-5.39)	2.99 (95% CI 1.92-4.64)	4.37 (95% CI 3.09-6.18)	5.02 (95% CI 3.47-7.26)
Gastrointestinal	2.82 (95% CI 2.17-3.67)	2.58 (95% CI 1.66-3.99)	3.22 (95% CI 2.32-4.46)	3.58 (95% CI 2.53-5.07)
Gynecological	1.82 (95% CI 1.32-2.51)	1.08 (95% CI 0.66-1.76)	2.03 (95% CI 1.36-3.01)	2.89 (95% CI 1.89-4.44)
Genitourinary	2.29 (95% CI 1.54-3.41)	1.86 (95% CI 0.97-3.57)	1.91 (95% CI 1.05-3.47)	2.37 (95% CI 1.21-4.63)
Other	3.08 (95% CI 2.32-4.09)	2.57 (95% CI 1.63-4.03)	3.42 (95% CI 2.42-4.83)	4.00 (95% CI 2.77-5.77)
Tumor stage				
Metastatic/advanced	-	1	-	-

Table 21. Multivariate models for overall survival in chemotherapy trials (Continued)

Not metastatic/advanced	-	0.48 (95% CI 0.41-0.55)	-	-
Region				
Northern America	-	-	1	1
Southern Europe	-	-	0.87 (95% CI 0.63-1.21)	0.82 (95% CI 0.58-1.14)
Australia & New Zealand	-	-	0.73 (95% CI 0.50-1.09)	0.69 (95% CI 0.46-1.05)
Eastern Europe	-	-	0.97 (95% CI 0.71-1.31)	0.96 (95% CI 0.70-1.31)
Northern Europe	-	-	1.02 (95% CI 0.75-1.40)	1.03 (95% CI 0.75-1.43)
Western Europe	-	-	1.02 (95% CI 0.75-1.39)	1.01 (95% CI 0.73-1.38)
Other	-	-	0.80 (95% CI 0.52-1.25)	0.97 (95% CI 0.58-1.61)
BMI				
< 19 kg/m ²	-	-	1	1
19-25 kg/m ²	-	-	0.83 (95% CI 0.72-0.97)	0.87 (95% CI 0.74-1.03)
25-30 kg/m ²	-	-	0.75 (95% CI 0.64-0.87)	0.78 (95% CI 0.66-0.92)
> 30 kg/m ²	-	-	0.64 (95% CI 0.54-0.77)	0.63 (95% CI 0.52-0.77)
Hct at baseline				
Hct 0-23.5%	-	-	-	1
Hct 23.5%-29.4%	-	-	-	0.90 (95% CI 0.60-1.34)
Hct 29.4%-35.3%	-	-	-	0.81 (95% CI 0.54-1.21)
Hct 35.3%-41.2%	-	-	-	0.70 (95% CI 0.46-1.07)
>Hct 41.2%	-	-	-	0.55 (95% CI 0.34-0.90)
Performance score				
ECOG 0, 1 or 2	-	-	-	1
ECOG 3 or 4	-	-	-	2.24 (95% CI 1.70-2.96)

*unadjusted HR based on the number of patients included in the respective model

** HR adjusted for the variables outlined in the columns

Table 22. Assessment of interaction for overall survival in chemotherapy trials

Overall survival, chemotherapy patients	Patients included	P value for interaction

Table 22. Assessment of interaction for overall survival in chemotherapy trials (Continued)

Total included	10441 (100%)	
Patient level characteristics		
Hb at baseline (continuous)	9945	0.4909
Hb at baseline (categorical 1)	9945	0.8848
Hb at baseline (categorical 2)	9945	0.9844
Tumor (categorical 1)	10399	0.3301
Tumor (categorical 2)	10399	0.3287
Sex	10441	0.0370
Age (continuous)	10430	0.4055
Age (categorical)	10430	0.4024
Hct (continuous)	7849	0.2527
Hct (categorical)	7849	0.2445
Baseline serum EPO (continuous)	3959	0.9996
Baseline serum EPO (categorical)	3959	0.4910
ECOG	8057	0.3408
ECOG (0,1,2 vs 3,4)	8057	0.9230
BMI (categorical)	8882	0.5227
History of thromboembolic events	6667	0.6838
History of cardiovascular events	7369	0.7809
History of hypertension	6667	0.9079
History of diabetes mellitus	5579	0.6186
Geographical region [region_cat]	10053	0.9283
Metastatic vs non-metastatic	8956	0.6040
Planned Hb ceiling (categorical 1)	10362	0.5706
Planned Hb ceiling (categorical 2)	10362	0.7743
Study level characteristics		
Placebo controlled	10441	0.7668
Randomization (adequate vs unclear)	10441	0.9035

Table 22. Assessment of interaction for overall survival in chemotherapy trials (Continued)

Allocation (adequate vs unclear)	10441	0.2609
Endpoint overall survival	10441	0.5819
Designed for long term follow up (binary)	10441	0.4744
Year of last patient randomized into study (categorical)	10441	0.1793
Source of data (company versus independent)	10441	0.5404
Iron category	10441	0.4098
Planned ESA treatment duration (categorical)	10441	0.7156
Planned weekly ESA dosage (categorical)	10441	0.3738
Planned frequency of ESA administration (categorical)	10441	0.1562

*P value for interaction based on LR test, patients with missing data are excluded from LR test

Table 23. Overall survival in chemotherapy trials, tests for interaction, univariate and multivariate models

Overall survival in chemotherapy trials	Bivariate ESA versus control			Multivariate ESA versus control		
Interaction term	ESA*sex			ESA*sex		
Adjusted for	-			age, sex, Hb, tumor type		
Patients excluded	-			-		
Patients included	n = 10441			n = 9892		
ESA versus control	HR	95% CI	P*	HR	95% CI	P*
Sex						
Male	0.96	0.87-1.06	0.0370	0.97	0.87-1.07	0.0362
Female	1.10	1.01-1.21		1.12	1.02-1.22	
Overall result, unadjusted	1.04	0.97-1.11	-	1.04	0.97-1.11	-

*P value LR test comparing model with and without interaction term

Table 24. Survival at predefined time points for all cancer patients*

Time after date of randomization	On study mortality data set			Overall survival data set		
	Deaths	ESA versus control HR (95% CI)**	P value	Deaths	ESA versus control HR (95% CI)*	P value
At 4 months	1193	1.13 (95% CI 1.01-1.27)	0.036	1419	1.12 (95% CI 1.01-1.24)	0.038

Table 24. Survival at predefined time points for all cancer patients* (Continued)

At 8 months	1425	1.16 (95% CI 1.04-1.29)	0.006	2678	1.06 (95% CI 0.98-1.14)	0.140
At 12 months	1507	1.17 (95% CI 1.06-1.30)	0.002	3561	1.06 (95% CI 0.99-1.14)	0.071
At 24 months	-	-	-	4537	1.06 (95% CI 1.00-1.13)	0.042
At 36 months	-	-	-	4833	1.05 (95% CI 0.99-1.12)	0.075
At 60 months	-	-	-	4977	1.06 (95% CI 1.00-1.12)	0.043

*13933 patients from all treatment populations were under observation.

**based on Cox fixed-effects model stratified by study

Table 25. Survival at predefined time points for all chemotherapy trials*

Time after date of randomization	On study mortality data set			Overall survival data set		
	Deaths	ESA versus control HR (95% CI)**	P value	Deaths	ESA versus control HR (95% CI)*	P value
At 4 months	792	1.03 (95% CI 0.89-1.18)	0.705	948	1.06 (95% CI 0.93-1.21)	0.383
At 8 months	992	1.08 (95% CI 0.95-1.23)	0.225	1870	0.99 (95% CI 0.91-1.09)	0.886
At 12 months	1072	1.10 (95% CI 0.98-1.25)	0.117	2552	1.01 (95% CI 0.93-1.09)	0.797
At 24 months	-	-	-	3246	1.04 (95% CI 0.97-1.11)	0.312
At 36 months	-	-	-	3452	1.03 (95% CI 0.96-1.10)	0.368
At 60 months	-	-	-	3544	1.04 (95% CI 0.97-1.11)	0.257

*10441 patients from the chemotherapy treatment population were under observation.

**based on Cox fixed-effects model stratified by study

Table 26. Survival at predefined time points for radiotherapy and radiochemotherapy trials*

Time after date of randomization	On study mortality data set			Overall survival data set		
	Deaths	ESA versus control HR (95% CI)**	P value	Deaths	Overall survival HR (95% CI)*	P value
At 4 months	74	1.40 (95% CI 0.88-2.23)	0.152	114	1.16 (95% CI 0.80-1.67)	0.440
At 8 months	82	1.51 (95% CI 0.97-2.35)	0.067	300	1.20 (95% CI 0.95-1.50)	0.119
At 12 months	82	1.51 (95% CI 0.97-2.35)	0.067	442	1.12 (95% CI 0.93-1.35)	0.235
At 24 months	-	-	-	686	1.05 (95% CI 0.91-1.22)	0.498
At 36 months	-	-	-	774	1.02 (95% CI 0.89-1.18)	0.753
At 60 months	-	-	-	826	1.03 (95% CI 0.90-1.18)	0.653

*1536 patients from the radiotherapy and radiochemotherapy treatment population were under observation.

**based on Cox fixed-effects model stratified by study

Table 27. Survival at predefined time points for patients from the "mixed" treatment group*

Time after date of randomization	On study mortality data set			Overall survival data set		
	Deaths	HR (95% CI)** ESA versus control On study mortality data set	P value	Deaths	HR (95% CI)* Overall survival data set	P value
At 4 months	24	1.53 (95% CI 0.63-3.69)	0.335	24	1.53 (95% CI 0.63-3.69)	0.335

*266 patients from two studies under observation, both studies included CLL patients only, patients received either chemotherapy or corticosteroids only. Since follow up in these studies was short data are provided at 4 months only.

**based on Cox fixed-effects model stratified by study

Table 28. Survival at predefined time points in trials without concomitant radiotherapy and/or chemotherapy*

Time after date of randomization	On study mortality data set			Overall survival data set		
	Deaths	ESA versus control HR (95% CI)**	P value	Deaths	ESA versus control HR (95% CI)*	P value
At 4 months	303	1.35 (95% CI 1.07-1.71)	0.010	333	1.27 (95% CI 1.02-1.58)	0.035
At 8 months	327	1.32 (95% CI 1.06-1.65)	0.013	484	1.24 (95% CI 1.03-1.48)	0.021
At 12 months	329	1.33 (95% CI 1.06-1.66)	0.012	543	1.28 (95% CI 1.08-1.52)	0.005
At 24 months	-	-	-	581	1.22 (95% CI 1.04-1.44)	0.017
At 36 months	-	-	-	583	1.22 (95% CI 1.04-1.44)	0.017

*1690 patients were under observation, patients were mainly not receiving chemotherapy or radiotherapy, table truncated after end of follow up.

**based on Cox fixed-effects model stratified by study

Table 29. Survival at predefined time points for all cancer patients, long term follow up studies only*

Time after date of randomization	On study mortality data set			Overall survival data set		
	Deaths	ESA versus control HR (95% CI)**	P value	Deaths	ESA versus control HR (95% CI)*	P value
At 4 months	790	1.22 (95% CI 1.06-1.41)	0.005	965	1.17 (95% CI 1.03-1.33)	0.015
At 8 months	970	1.25 (95% CI 1.10-1.42)	0.001	2023	1.08 (95% CI 0.99-1.18)	0.097
At 12 months	1050	1.26 (95% CI 1.11-1.42)	<0.001	2823	1.08 (95% CI 1.00-1.16)	0.046

Table 29. Survival at predefined time points for all cancer patients, long term follow up studies only* (Continued)

At 24 months	-	-	-	3743	1.07 (95% CI 1.01-1.15)	0.032
At 36 months	-	-	-	4028	1.06 (95% CI 0.99-1.13)	0.077
At 60 months	-	-	-	4169	1.07 (95% CI 1.00-1.13)	0.041

*8974 patients from all treatment populations stemming from trials designed for long term follow up were under observation.

**based on Cox fixed-effects model stratified by study

Table 30. Survival at predefined time points in chemotherapy trials, long term follow up studies only*

Time after date of randomization	On study mortality data set			Overall survival data set		
	Deaths	ESA versus control HR (95% CI)**	P value	Deaths	ESA versus control HR (95% CI)*	P value
At 4 months	499	1.14 (95% CI 0.95-1.36)	0.153	604	1.14 (95% CI 0.97-1.34)	0.119
At 8 months	658	1.18 (95% CI 1.01-1.37)	0.040	1346	1.01 (95% CI 0.91-1.13)	0.842
At 12 months	738	1.20 (95% CI 1.03-1.39)	0.016	1952	1.03 (95% CI 0.94-1.13)	0.527
At 24 months	-	-	-	2594	1.05 (95% CI 0.97-1.14)	0.191
At 36 months	-	-	-	2789	1.04 (95% CI 0.97-1.12)	0.290
At 60 months	-	-	-	2878	1.05 (95% CI 0.98-1.13)	0.182

*6509 patients from the chemotherapy treatment population stemming from trials that were designed for long term follow up were under observation.

** Based on Cox fixed-effects model stratified by study

Table 31. Survival at predefined time points in radiotherapy and radiochemotherapy trials, long term follow up studies only*

Time after date of randomization	On study mortality data set			Overall survival data set		
	Deaths	ESA versus control HR (95% CI)**	P value	Deaths	ESA versus control HR (95% CI)*	P value
At 4 months	74	1.40 (95% CI 0.88-2.23)	0.152	114	1.16 (95% CI 0.80-1.67)	0.440
At 8 months	82	1.51 (95% CI 0.97-2.35)	0.067	299	1.21 (95% CI 0.96-1.51)	0.107
At 12 months	82	1.51 (95% CI 0.97-2.35)	0.067	441	1.12 (95% CI 0.93-1.36)	0.219
At 24 months	-	-	-	685	1.06 (95% CI 0.91-1.22)	0.477
At 36 months	-	-	-	773	1.03 (95% CI 0.89-1.18)	0.729
At 60 months	-	-	-	825	1.03 (95% CI 0.90-1.19)	0.631

*1476 patients from the radiotherapy and radiochemotherapy treatment population stemming from trials designed for long term follow up were under observation.

**based on Cox fixed-effects model stratified by study

Table 32. Survival at predefined time points for patients from the "mixed" treatment group, long term follow up studies only*

Time after date of randomization	Deaths	On study mortality data set	P value	Deaths	Overall survival data set	P value
At 4 months	-	-	-	-	-	-

*266 patients from two studies under observation, both studies included CLL patients only, patients received either chemotherapy or corticosteroids only. Both studies were not designed for long term follow-up and are therefore not reported for this sensitivity analysis.

Table 33. Survival at predefined time points in trials without concomitant radiotherapy and/or chemotherapy, long term follow up studies only*

Time after date of randomization	On study mortality data set			Overall survival data set		
	Deaths	ESA versus control HR (95% CI)**	P value	Deaths	ESA versus control HR (95% CI)*	P value
At 4 months	217	1.38 (95% CI 1.05-1.81)	0.018	247	1.26 (95% CI 0.98-1.62)	0.070
At 8 months	230	1.37 (95% CI 1.05-1.78)	0.018	378	1.23 (95% CI 1.00-1.51)	0.045
At 12 months	230	1.37 (95% CI 1.06-1.78)	0.018	430	1.27 (95% CI 1.05-1.54)	0.013
At 24 months	-	-	-	464	1.22 (95% CI 1.02-1.47)	0.032
At 36 months	-	-	-	466	1.22 (95% CI 1.02-1.47)	0.032

*989 patients were under observation, patients were mainly not receiving chemotherapy or radiotherapy, table truncated after end of follow up, only patients stemming from studies with long term follow up were included. For the no treatment population this was actually only one study.

**based on Cox fixed-effects model stratified by study

Table 34. Clinical relevance for overall estimate of on study mortality applied to hypothetical populations

Underlying survival probability	ESA versus control HR (95% CI)	Number needed to treat (95% CI)
On study mortality, all cancer patients		
95%	1.17 (95% CI 1.06-1.30)	NNTH 121 (NNTH 69 to NNTH 343)
80%		NNTH 34 (NNTH 19 to NNTH 94)
70%		NNTH 24 (NNTH 14 to NNTH 67)
On study mortality, chemotherapy trials		

Table 34. Clinical relevance for overall estimate of on study mortality applied to hypothetical populations (Continued)

95%	1.10 (95% CI 0.98-1.24)	NNTH 206 (NNTH 86 to ∞ to NNTB 1026)
80%		NNTH 57 (NNTH 24 to ∞ to NNTB 279)
70%		NNTH 41 (NNTH 17 to ∞ to NNTB 200)

APPENDICES

Appendix 1. Search strategies

Search strategies for IPD meta-analysis update

Database: Ovid MEDLINE(R)

-
- 1 exp ERYTHROPOIETIN/
 - 2 exp ERYTHROPOIETIN, RECOMBINANT/
 - 3 erythropoietin.mp.
 - 4 erythropoiesis.mp.
 - 5 exp EPOETIN ALFA/
 - 6 epoetin.mp.
 - 7 epo.mp.
 - 8 epoetin alfa.mp.
 - 9 epoetin beta.mp.
 - 10 eprex.mp.
 - 11 neorecormon.mp.
 - 12 aranesp.mp.
 - 13 procrit.mp.
 - 14 recombinant erythropoietin.mp.
 - 15 darbepoetin alfa.mp.
 - 16 darbepoetin.mp.
 - 17 RECEPTORS, ERYTHROPOIETIN/
 - 18 CERA.mp.
 - 19 or/1-18
 - 20 exp ANEMIA/dt, th [Drug Therapy, Therapy]
 - 21 anaemia.mp.
 - 22 anemia.mp.
 - 23 (anemi\$ adj3 cancer).mp.
 - 24 (anaemi\$ adj3 cancer).mp.

- 25 or/20-24
- 26 exp Neoplasms/
27 malignan\$.mp.
28 cancer\$.mp.
29 oncolog\$.tw.
30 myelodysplas\$.tw.
31 chemotherapy.mp.
32 tumo?r\$.mp.
33 carcinom\$.mp.
- 34 or/26-33
- 35 19 and 25
- 36 34 and 25
- 37 randomized controlled trial.pt.
38 controlled clinical trial.pt.
39 randomized controlled trials/
40 random allocation/
41 double blind method/
42 single blind method/
43 or/37-42
44 (ANIMALS not HUMANS).sh.
45 43 not 44
46 clinical trial.pt.
47 exp clinical trials/
48 (clin\$ adj25 trial\$.ti,ab.
49 ((singl\$ or doubl\$ or trebl\$ or tripl\$) adj25 (blind\$ or mask\$)).ti,ab.
50 placebos/
51 placebo\$.ti,ab.
52 random\$.ti,ab.
53 research design/
54 or/46-53
55 54 not 44
56 55 not 45
57 comparative study/
58 exp evaluation studies/
59 follow up studies/

- 60 prospective studies/
61 (control\$ or prospectiv\$ or volunteer\$).ti,ab.
62 or/57-61
63 62 not 44
64 63 not (45 or 56)
65 45 or 56 or 64
66 36 and 65

Database: Ovid (Embase)**Database: Ovid (Embase)**

- 1 erythropoietin.mp.
2 exp ERYTHROPOIETIN/
3 exp RECOMBINANT ERYTHROPOIETIN/
4 epoetin.mp
5 epo.mp.
6 eprex.mp
7 neorecormon.mp
8 procrit.mp
9 recombinant erythropoietin.mp.
10 darbepoetin alfa.mp.
11 exp NOVEL ERYTHROPOIESIS STIMULATING PROTEIN/
12 aranesp.mp.
13 nesp.mp
14 exp darbepoetin/
15 exp darbepoietin alfa/
16 exp CONTINUOUS ERYTHROPOIESIS RECEPTOR ACTIVATOR
17 CERA.mp
18 Or/1-17
19 exp ANEMIA/
20 anemia.mp.
21 anaemi\$.tw.
22 anemi\$.mp.
23 (anemi\$ adj3 cancer\$).mp.
24 (anaemi\$ adj3 cancer\$).mp.
25 Or/19-24
26 malignan\$.mp.

- 27 cancer\$.mp.
- 28 exp CANCER/
- 29 exp NEOPLASM/
- 30 neoplasm\$.mp.
- 31 oncology.mp.
- 32 exp ONCOLOGY/
- 33 exp MYELODYSPLASIA/
- 34 myelodysplas\$.tw.
- 35 chemotherapy.mp.
- 36 exp CHEMOTHERAPY/
- 37 exp TUMOR/
- 38 tumo?r\$.mp.
- 39 carcinom\$.mp.
- 40 Or/26-40
- 41 randomized controlled trial/
- 42 exp clinical trial/
- 43 exp controlled study/
- 44 double blind procedure/
- 45 randomization/
- 46 placebo/
- 47 single blind procedure/
- 48 (control\$ adj (trial\$ or stud\$ or evaluation\$ or experiment\$)).mp.
- 49 ((singl\$ or doubl\$ or trebl\$ or tripl\$) adj5 (blind\$ or mask\$)).mp.
- 50 (placebo\$ or matched communities or matched schools or matched populations).mp.
- 51 (comparison group\$ or control group\$).mp.
- 52 (clinical trial\$ or random\$).mp.
- 53 (quasiexperimental or quasi experimental or pseudo experimental).mp.
- 54 matched pairs.mp.
- 55 or/41-54
- 56 18 and 25
- 57 55 and 40
- 58 57 and 56

CENTRAL

ID Search

- #1 (erythropoietin)
- #2 MeSH descriptor Erythropoietin explode all trees
- #3 epoetin
- #4 epo
- #5 (epoetin next alfa)
- #6 (epoetin next beta)
- #7 (darbepoetin next alfa)
- #8 eprex
- #9 neorecormon
- #10 aranesp
- #11 procrit
- #12 (recombinant near erythropoietin)
- #13 "continuous erythropoietin receptor activation"
- #14 "continuous erythropoietin receptor activator"
- #15 CERA
- #16 C.E.R.A.
- #17 erythropoiesis
- #18 darbepoetin
- #19 (#1 OR #2 OR #3 OR #4 OR #5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15 OR #16 OR #17 OR #18)
- #20 anemia
- #21 anaemia
- #22 MeSH descriptor Anemia explode all trees
- #23 (anemi* near cancer)
- #24 (anaemi* near cancer)
- #25 (#20 OR #21 OR #22 OR #23 OR #24)
- #26 (#19 AND #25)

Appendix 2. List of variables evaluated

1. Variables to assess baseline imbalances

The following list provides pre-specified and exploratory variables that were used to assess baseline imbalances. MAIN variables, i.e. variables that were pre-specified in advance ([Langensiepen 2002](#)) are highlighted in **BOLD**. All other variables are considered to be exploratory. All variables refer to patient level data, unless otherwise specified. The technical name of the variable is given in [brackets].

PATIENT

1. Hemoglobin at baseline (randomization): continuous and categorical

a. ($Hb \leq 8$ g/dL versus 8 g/dL < $Hb \leq 10$ g/dL versus 10 g/dL < $Hb \leq 12$ g/dL versus 12 g/dL < $Hb \leq 14$ g/dL versus $Hb > 14$ g/dL) [hgb_cat1]

b. by 1 g/dL increments, i.e. 8 g/dL < $Hb \leq 9$ g/dL versus 9 g/dL < $Hb \leq 10$ g/dL versus 10 g/dL < $Hb \leq 11$ g/dL versus 11 g/dL < $Hb \leq 12$ g/dL versus 12 g/dL < $Hb \leq 13$ g/dL versus 13 g/dL < $Hb \leq 14$ g/dL versus > 14 g/dL [hgb_cat2]

2. Hematocrit at baseline (randomization): continuous and categorical (Hct \leq 23.5% versus 23.5% < Hct \leq 29.4% versus 29.4% < Hct \leq 35.3% versus 35.3% < Hct \leq 41.2% versus Hct > 41.2%) [hct_cat]

Note: use hematocrit values only if measurements was made, mathematical conversions from hemoglobin to hematocrit are not allowed

3. Serum EPO level at baseline before first study drug: continuous and categorical (< 25 mU/ml versus 25 - < 100 mU/ml versus 100 - < 200 mU/ml versus \geq 200 mU/ml) (Littlewood 2003). Note: two categories were added: "200 - < 500 mU/ml versus \geq 500 mU/ml") [serepo]

4. Gender: dichotomous (male versus female) [sex]

5. Age at randomization: continuous and categorical (< 18 years versus 18 to < 35 years versus 35 to < 45 years versus 45 to < 55 years versus 55 to < 65 years versus 65 to < 75 years versus \geq 75 years) [age_cat]

6. Body mass index (BMI): continuous and categorical (BMI < 19 kg/m² versus 19 \leq BMI < 25 kg/m² versus 25 \leq BMI < 30 kg/m² versus BMI \geq 30 kg/m²) [bmi_cat]

7. ECOG performance score: categorical

a. each score value (0 versus 1 versus 2 versus 3 versus 4) [ecog_b]

b. 0, 1 or 2 versus 3 or 4 [ecog_cat]

8. History of thromboembolic event EXCLUDING central line associated thrombosis? Categorical (yes versus no) [hxthrom]

9. History of cardiovascular disease including coronary artery disease, myocardial infarction, atrial fibrillation or congestive heart disease? Categorical (yes versus no) [hxcardio]

10. History of hypertension? Categorical (yes versus no) [hxhyper]

11. History of diabetes mellitus? Categorical (yes versus no) [hxdiab]

12. Geographical region: categorical (Northern America versus Northern, Western, Southern Europe versus Australia/New Zealand versus Eastern Europe versus Americas versus other) [region_cat]

TUMOR

13. Tumor type with different categorizations

a. few categories (solid tumors versus hematological malignancies; note: chronic lymphocytic leukemia will be coded as lymphoma)

[tumor_cat1]

b. more categories (hematological versus breast cancer versus head and neck versus lung cancer versus other cancer). Note: the categorization was

changed as follows: hematological versus breast cancer versus head and neck versus lung cancer versus gastrointestinal versus gynecological

versus genitourinary versus other cancer [tumor_cat2]

c. many categories (each cancer entity will be kept as separate category). Note: category c was not applied in the analysis

14. Disease stage at ESA study entry: categorical (limited disease versus locally advanced versus extensive/metastatic disease versus other). Note: data

quality did only permit to dichotomize the data into metastatic or advanced versus not metastatic or not advanced. [stagem_cat1]

15. Disease status at ESA study entry: categorical (untreated versus complete response versus partial response or stable disease versus progression

or progressive disease or relapsed versus not evaluable versus not evaluated). Note: data quality did not permit to use this variable.

16. Time from tumor diagnosis to randomization [cancertime]

TUMOR TREATMENT

17. Cancer treatment modality (note this replaces the analysis for chemotherapy induced anemia versus anemia of cancer):

a. Categorical at patient level (non-platinum chemotherapy/combined modality treatment versus platinum chemotherapy/combined modality treatment

versus radiotherapy versus radiochemotherapy versus none versus unclear/mixed versus other). Note: radiotherapy and radiochemotherapy were kept as separate categories [popchmg], for a sensitivity analyses both categories were collapsed into one category [popispm_cat]

2. Variables to assess study design

The following list provides pre-specified and exploratory variables that were used to assess the study design of the included trials. MAIN variables, i.e. variables that were pre-specified in advance (Langensiepen 2002) are highlighted in **BOLD**. All other variables are considered to be exploratory. All variables refer to the study level, unless otherwise specified.

1. **Randomization: categorical (adequate versus unclear versus inadequate) [randomisation]**

2. **Concealment of allocation: categorical (adequate versus unclear versus inadequate) [allocation]**

3. **Placebo controlled: dichotomous (yes versus no/unclear) [placebo]**

4. **Blinded outcome assessment: dichotomous (yes, no/unclear; this assessment may vary between outcomes)**

a. PFS: Was there independent and blinded adjudication of events and cause of deaths?

b. TEE: Was there independent and blinded adjudication of events?

5. IPD submitted by pharmaceutical company or independent investigators: categorical (pharmaceutical company versus independent investigators versus other) [source]

6. Was the outcome of interest assessed as an endpoint (primary or secondary) or as an adverse event only? dichotomous (yes (endpoint) versus no (adverse event only)) and categorical (primary versus secondary versus an adverse event only) [endpoint]. Note: this variable was only assessed categorical, not dichotomous

7. Was the study designed to assess long-term follow-up? dichotomous versus (yes versus no) [longfu], note: assessed in sensitivity analysis, long-term follow-up was defined as planned follow-up of at least 12 months after end of active treatment period

8. Calendar year of last patient randomized per study (to be calculated based on the individual patient data): continuous [calyear] and categorical (calendar time split in 5 years period) [calyear_cat]

9. **Were less than 10% of subjects within each study arm excluded from the analysis and was the ratio of exclusions between arms less than a 2:1?**

10. Actual study size: continuous and dichotomous (small (n overall < 200) versus large (n overall ≥ 200)), note: not assessed

11. Prematurely terminated or halted study or completed by own study protocol: dichotomous (terminated/halted versus completed) [stop], note: assessed in sensitivity analysis

12. Median time from randomization to censoring per study, separate for each outcome (to be calculated based on the individual patient data): continuous, note: not assessed

3. Variables to assess effect modification

The following list provides pre-specified and exploratory variables that were examined in analyses of effect modification. MAIN variables, i.e. variables that were pre-specified in advance (Langensiepen 2002) are highlighted in **BOLD**. All other variables were considered to be exploratory. All variables refer to patient level data, unless otherwise specified. The technical name of the variable is given in [brackets].

PATIENT

1. **Hemoglobin at baseline (randomization): continuous and categorical**

a. (Hb ≤ 8 g/dL versus 8 g/dL < Hb ≤ 10 g/dL versus 10 g/dL < Hb ≤ 12 g/dL versus 12 g/dL < Hb ≤ 14 g/dL versus Hb > 14 g/dL) [hgb_cat1]

b. by 1 g/dL increments, i.e. 8 g/dL < Hb ≤ 9 g/dL versus 9 g/dL < Hb ≤ 10 g/dL versus 10 g/dL < Hb ≤ 11 g/dL versus 11 g/dL < Hb ≤ 12 g/dL versus 12 g/dL < Hb ≤ 13 g/dL versus 13 g/dL < Hb ≤ 14 g/dL versus > 14 g/dL [hgb_cat2]

2. Hematocrit at baseline (randomization): continuous and categorical (Hct \leq 23.5% versus 23.5% < Hct \leq 29.4% versus 29.4% < Hct \leq 35.3% versus 35.3% < Hct \leq 41.2% versus Hct > 41.2%) [hct_cat]
Note: Use hematocrit values only if measurements was made, mathematical conversions from hemoglobin to hematocrit are not allowed.
3. Serum EPO level at baseline before first study drug: continuous and categorical (< 25 mU/ml versus 25 - < 100 mU/ml versus 100 - < 200 mU/ml versus \geq 200 mU/ml) (Littlewood 2003). Note: two categories were added: “200 - < 500 mU/ml versus \geq 500 mU/ml”) [serepo]
4. Gender: dichotomous (male versus female) [sex]
5. Age at randomization: continuous and categorical (< 18 years versus 18 to < 35 years versus 35 to < 45 years versus 45 to < 55 years versus 55 to < 65 years versus 65 to < 75 years versus \geq 75 years) [age_cat]
6. Body mass index (BMI): continuous and categorical (BMI < 19 kg/m² versus 19 \leq BMI < 25 kg/m² versus 25 \leq BMI < 30 kg/m² versus BMI \geq 30 kg/m²) [bmi_cat]
7. ECOG performance score: categorical
- a. each score value (0 versus 1 versus 2 versus 3 versus 4) [ecog_b]
- b. 0, 1 or 2 versus 3 or 4 [ecog_cat]
8. History of thromboembolic event EXCLUDING central line associated thrombosis? Categorical (yes versus no) [hxthrom]
9. History of cardiovascular disease including coronary artery disease, myocardial infarction, atrial fibrillation or congestive heart disease? (yes versus no) [hxcadio]
10. History of hypertension? Categorical (yes versus no) [hxhyper]
11. History of diabetes mellitus? Categorical (yes versus no) [hxdiab]
12. Geographical region: categorical (Northern America versus Northern, Western, Southern Europe versus Australia/New Zealand versus Eastern Europe versus Americas versus other) [region_cat]

TUMOR

13. Tumor type with different categorizations

- a. few categories (solid tumors versus hematological malignancies; note: chronic lymphocytic leukemia will be coded as lymphoma) [tumor_cat1]
- b. more categories (hematological versus breast cancer versus head and neck versus lung cancer versus other cancer). Note: the categorization was changed as follows: hematological versus breast cancer versus head and neck versus lung cancer versus gastrointestinal versus gynecological versus genitourinary versus other cancer [tumor_cat2]
- c. many categories (each cancer entity will be kept as separate category). Note: category c was not applied in the analysis
14. Disease stage at ESA study entry: categorical (limited disease versus locally advanced versus extensive/metastatic disease versus other). Note: data quality did only permit to dichotomize the data into metastatic or advanced versus not metastatic or not advanced. [stagem_cat1]
15. Disease status at ESA study entry: categorical (untreated versus complete response versus partial response or stable disease versus progression or progressive disease or relapsed versus not evaluable versus not evaluated). Note: data quality did not permit to use this variable.
16. Time from tumor diagnosis to randomization [cancertime]

TUMOR TREATMENT

17. Cancer treatment modality (note this replaces the analysis for chemotherapy induced anemia versus anemia of cancer):

Erythropoietin or Darbepoetin for patients with cancer - meta-analysis based on individual patient data (Review)

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a. Categorical at patient level (non-platinum chemotherapy/combined modality treatment versus platinum chemotherapy/combined modality treatment versus radiotherapy versus radiochemotherapy versus none versus unclear/mixed versus other). Note: data quality did not allow to differentiate platinum containing versus non platinum chemotherapy.

b. **Categorical at study level (mainly chemotherapy/combined modality treatment (both platinum containing and platinum free) versus mainly radiotherapy/radiochemotherapy versus none versus unclear/mixed versus other).** Note: radiotherapy and radiochemotherapy were kept as separate categories [popchmg], for a sensitivity analyses both categories were collapsed into one category [popispm_cat]

ESA TREATMENT

18. **Iron supplementation policy as per study protocol (study level information): categorical (fixed versus as needed by study protocol or by discretion of physician versus no iron versus no statement).** [iron_cat] Note: the category “by discretion of physician” was amended to “by discretion of physician or institutional policy”.

19. **Planned duration of ESA treatment as per study protocol (study level information): continuous and categorical (up to 8 weeks versus 9 to 16 weeks versus > 17 weeks versus not applicable)** [plandur_cat].

Note: studies that did not indicate a specific number of weeks for ESA treatment duration were categorized as “until end of chemotherapy or radiotherapy”, if indicated.

20. Planned weekly ESA dosage as defined in the study protocol (starting dose, study level information): continuous and categorical (EPO < 40,000 IU/week or darbepoetin < 100 µg/week versus EPO = 40,000 IU/week or darbepo = 100 µg/week versus EPO > 40,000 IU/week or darbepoetin > 100 µg /week) [weekesa_cat]

21. Planned frequency of ESA applications as defined in the study protocol (study level information): categorical (TIW or more often versus QW versus Q2W versus Q3W versus Q4W). Note: the categorization was simplified to (TIW or more often versus QW versus Q2W or more often). [planfreq_cat]

22. Planned hemoglobin ceiling target i.e. when ESA had to be stopped according to the study protocol (study level information): continuous and categorical

a. Hb ≤ 11 versus 11 g/dL < Hb ≤ 13 g/dL versus 13 g/dL < Hb ≤ 15 g/dL versus > Hb > 15 g/dL [ceiling_cat1]

b. by 1 g/dL increments, i.e. 8 g/dL < Hb ≤ 9 g/dL versus 9 g/dL < Hb ≤ 10 g/dL versus 10 g/dL < Hb ≤ 11 g/dL versus 11 g/dL < Hb ≤ 12 g/dL versus 12 g/dL < Hb ≤ 13 g/dL versus 13 g/dL < Hb ≤ 14 g/dL versus 14 g/dL < Hb ≤ 15 g/dL versus 15 g/dL < Hb ≤ 16 g/dL versus 16 g/dL < Hb ≤ 17 g/dL versus 17 g/dL < Hb ≤ 18 g/dL versus > 18 g/dL [ceiling_cat2]

23. Maximal hemoglobin within 4 weeks before event or end of study: continuous and categorical (Hb ≤ 8 g/dL versus 8 g/dL < Hb ≤ 10 g/dL versus 10 g/dL < Hb ≤ 12 g/dL versus 12 g/dL < Hb ≤ 14 g/dL versus 14 g/dL < Hb ≤ 16 g/dL versus 16 g/dL < Hb ≤ 18 g/dL versus Hb > 18 g/dL), TIME DEPENDENT VARIABLE. Note: this variable has not been applied in the analysis.

24. Maximal hematocrit within 4 weeks before event or end of study: continuous and categorical (Hct hct ≤ 23.5% versus 23.5% < hct ≤ 29.4% versus 29.4% < hct ≤ 35.3% versus 35.3% < hct ≤ 41.2% versus 41.2% < hct ≤ 47.1% versus hct > 53%), TIME DEPENDENT VARIABLE. Note: this variable has not been applied in the analysis.

4. Other protocol amendments

The variable FIX (not listed above) was amended with one category: “adjusted” for patients who received a fix dose of drug depending on their age or weight category. This category was added to differentiate between a truly weight based dosing scheme.

Appendix 3. Sensitivity analyses

Sensitivity analyses for studies with aggregated survival data

Ten studies were eligible for the IPD meta-analysis but individual patient data could not be retrieved. For six of these studies (Antonadou 2001; Bamias 2003; Blohmer 2003; Mystakidou 2005; Overgaard 2007) results for survival were either reported in the literature or provided by the investigator. Overall, the inclusion of these results in the meta-analyses did not lead to important changes.

Table 1: Sensitivity analyses for effect of missing studies, on study mortality

Two-stage log-rank fixed-effect meta-analysis	Results based on IPD analysis	Including additional literature based data
ESA versus control	HR (95% CI)	HR (95% CI)
On study mortality, all cancer patients*	1.17 (1.06-1.30)	1.17 (1.06-1.30)
On study mortality, chemotherapy trials	1.10 (0.98-1.24)	1.11 (0.98-1.25)

*Not included: Overgaard 2007, no on study mortality data reported

Table 2: Sensitivity analyses for effect of missing studies, overall survival

Two-stage log-rank fixed-effect meta-analysis	Results based on IPD analysis	Including additional literature based data
ESA versus control	HR (95% CI)	HR (95% CI)
Overall survival, all cancer patients	1.06 (1.00-1.12)	1.06 (1.00-1.11)
Overall survival, chemotherapy trials	1.04 (0.97-1.11)	1.04 (0.97-1.11)

Sensitivity analyses for on study mortality in all cancer patients

Classification of studies into different treatment populations

In study 83322 (Debus 2006) patients with non-resectable NSCLC received chemotherapy which was followed by radiotherapy. ESA was given during the treatment of chemotherapy and radiotherapy. However, only patients who achieved CR, PR or stable disease were subsequently treated with radiotherapy (39.5% of the ESA patients and 44.2% of the control patients did not receive radiotherapy, information taken from CSR). Since the chemotherapy was followed by radiotherapy after a short interval, the study was classified as “radiochemotherapy”. However, it could also be argued that the study should be classified as “combined modality treatment” because radiotherapy was given after chemotherapy or as “mixed” population, because less than 70% of the treatment population actually received radiotherapy. Both options were tested in a sensitivity analysis, results for on study mortality for the various treatment subsets and LR test for difference between subsets of studies did not change, see below.

Table 3: Sensitivity analyses for on study mortality in all cancer patients

Two-stage meta-analysis based on random-effects Cox model	Study 83322 in radiochemotherapy treatment group	Study 83322 in mixed treatment group	Study 83322 in chemotherapy treatment group
ESA versus control	HR (95% CI)	HR (95% CI)	HR (95% CI)
Chemotherapy	1.09 (0.97-1.23)	1.09 (0.97-1.23)	1.10 (0.98-1.24)
Radiochemotherapy	1.47 (0.83-2.59)	2.34 (0.42-13.03)	2.34 (0.42-13.03)
Radiotherapy	1.51 (0.73-3.12)	1.51 (0.73-3.12)	1.51 (0.73-3.12)

(Continued)

Mixed	1.50 (0.62-3.66)	1.42 (0.86-2.34)	1.50 (0.62-3.66)
None	1.32 (1.06-1.65)	1.32 (1.06-1.65)	1.32 (1.06-1.65)
Overall	1.16 (1.05-1.29)	1.16 (1.05-1.29)	1.16 (1.05-1.29)
LR test	0.4234	0.3607	0.4290

Sensitivity analysis for on study mortality: mixed treatment group

In two studies with CLL patients ([Rose 1994](#); [CC2574-P-174](#)) about 40% of the patients received corticosteroids and 60% of patients received chemotherapy during study. Since the definition for treatment populations was set at 70% (i.e. 70% of a trial population had to have received the planned anticancer treatment) these two studies were classified and analyzed in the “mixed” treatment population. In a sensitivity analysis we included these two studies in the “chemotherapy” population, for results see below. Overall, the results did not change.

Table 4: Sensitivity analyses for on study mortality in all cancer patients

Two-stage meta-analysis based on random-effects Cox model	Mixed treatment group separate subset	Mixed treatment group merged to chemotherapy treatment group
ESA versus control	HR (95% CI)	HR (95% CI)
Chemotherapy	1.09 (0.97-1.23)	1.10 (0.97-1.24)
Radiochemotherapy	1.47 (0.83-2.59)	1.47 (0.83-2.59)
Radiotherapy	1.51 (0.73-3.12)	1.51 (0.73-3.12)
Mixed	1.50 (0.62-3.66)	-
None	1.32 (1.06-1.65)	1.32 (1.06-1.65)
Overall	1.16 (1.05-1.29)	1.16 (1.05-1.29)
LR test	0.4234	0.3382

Sensitivity analyses for on study mortality: radiochemotherapy treatment population

In five studies patients received both radiotherapy and chemotherapy. Since patients in these studies received chemotherapy, a myelosuppressive effect of the chemotherapy cannot be excluded and it might be argued that those studies should be evaluated in the chemotherapy population. For a sensitivity analysis these patients were included in the chemotherapy treatment population, overall, the results did not change, see below.

Table 5: Sensitivity analyses for on study mortality in all cancer patients

Two-stage meta-analysis based on random-effects Cox model	Radiochemotherapy treatment group merged to radiotherapy treatment group	Radiochemotherapy treatment group merged to chemotherapy treatment group
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(Continued)

ESA versus control	HR (95% CI)	HR (95% CI)
Chemotherapy	1.09 (0.97-1.23)	1.11 (0.98-1.25)
Radiotherapy	1.48 (0.95-2.32)	1.51 (0.73-3.12)
Mixed	1.50 (0.62-3.66)	1.50 (0.62-3.66)
None	1.32 (1.06-1.65)	1.32 (1.06-1.65)
Overall	1.16 (1.05-1.29)	1.16 (1.05-1.29)
LR test	0.2715	0.4246

Sensitivity analysis for on study mortality: exclusion of study without date of randomization

For one study (study 36158 (Boogaerts 2003), chemotherapy population) the date of randomization was not available and was replaced with the date of “first study drug” as provided by the investigators/sponsors of the study. For a sensitivity analysis we excluded this study, for results see below. Overall, inclusion or exclusion of this study did not affect the overall results and the test for differences between treatment populations did not change.

Table 6: Sensitivity analyses for on study mortality in all cancer patients

Two-stage meta-analysis based on random-effects Cox model	Chemotherapy subset including study 36158	Chemotherapy subset without study 36158
ESA versus control	HR (95% CI)	HR (95% CI)
Chemotherapy	1.09 (0.97-1.23)	1.09 (0.97-1.24)
Radiochemotherapy	1.47 (0.83-2.59)	1.47 (0.83-2.59)
Radiotherapy	1.51 (0.73-3.12)	1.51 (0.73-3.12)
Mixed	1.50 (0.62-3.66)	1.50 (0.62-3.66)
None	1.32 (1.06-1.65)	1.32 (1.06-1.65)
Overall	1.16 (1.05-1.29)	1.16 (1.05-1.29)
LR test	0.4234	0.4279

Sensitivity analyses for on study mortality chemotherapy patients: exclusion of studies with different concomitant treatments in active and control arm

For two studies concomitant treatments in the active and the control arm were not identical, i.e. in one study 21481 (Thomas 2008) the transfusion trigger in the ESA arm was 12 g/dL and in the control arm 10 g/dL. In another study 70404 (Strauss 2008) radiotherapy for patients in the control arm started two weeks earlier compared to patients in the ESA arm. For a sensitivity analysis these studies were excluded, for results see below. Overall, exclusion of these two studies from the radiochemotherapy population (Thomas 2008; Strauss 2008) did not change the overall result and did also not change the differences between the treatment populations.

Table 7: Sensitivity analyses for on study mortality in all cancer patients

Two-stage meta-analysis based on random-effects Cox model	Radiochemotherapy subset including studies 21481, 70404	Radiochemotherapy subset without studies 21481, 70404
ESA versus control	HR (95% CI)	HR (95% CI)
Chemotherapy	1.09 (0.97-1.23)	1.09 (0.97-1.23)
Radiochemotherapy	1.47 (0.83-2.59)	1.50 (0.84-2.67)
Radiotherapy	1.51 (0.73-3.12)	1.51 (0.73-3.12)
Mixed	1.50 (0.62-3.66)	1.50 (0.62-3.66)
None	1.32 (1.06-1.65)	1.32 (1.06-1.65)
Overall	1.16 (1.05-1.29)	1.16 (1.05-1.29)
LR test	0.4234	0.4063

Sensitivity analysis for on study mortality in all cancer patients: exclusion of studies with different iron policies in active and control arm

For seven studies ([Machtay 2007](#); [Untch 2008](#); [Moebus 2007](#); [Debus 2006](#); [Savonije 2005](#); [EPO-GER-20](#); [OBE/EPO-INT-03](#)) the iron policies in the active and the control arm were different, for a sensitivity analysis we excluded these studies from the analysis, for results see below. Overall, the results did not change.

Table 8: Sensitivity analyses for on study mortality in all cancer patients

Two-stage meta-analysis based on random-effects Cox model	Including studies with different iron policies	Excluding studies with different iron policies
ESA versus control	HR (95% CI)	HR (95% CI)
Chemotherapy	1.09 (0.97-1.23)	1.11 (0.98-1.26)
Radiochemotherapy	1.47 (0.83-2.59)	4.13 (0.46-36.94)
Radiotherapy	1.51 (0.73-3.12)	1.48 (0.64-3.45)
Mixed	1.50 (0.62-3.66)	1.50 (0.62-3.66)
None	1.32 (1.06-1.65)	1.32 (1.06-1.65)
Overall	1.16 (1.05-1.29)	1.17 (1.05-1.30)
LR test	0.4234	0.3974

Sensitivity analyses for on study mortality: exclusion of studies terminated prematurely

Fourteen studies were terminated prematurely ([Charu 2007](#); [CC2574-P-174](#); [Quirt 1996](#); [Goss 2005](#); [Wright 2007](#); [EPO-GBR-7](#); [EPO-GER-20](#); [Debus 2006](#); [Thomas 2008](#); [Leyland-Jones 2003](#); [Grote 2005](#); [OBE/EPO-INT-03](#); [Vadhan-Raj 2004](#); [Machtay 2007](#)), for a sensitivity analysis we excluded these studies from the analysis, for results see below. Apparently, exclusion of these studies reduced the overall effect estimate; however, the change was small.

Table 9: Sensitivity analyses for on study mortality in all cancer patients

Two-stage meta-analysis based on random-effects Cox model	Including prematurely stopped studies	Excluding prematurely stopped studies
ESA versus control	HR (95% CI)	HR (95% CI)
Chemotherapy	1.09 (0.97-1.23)	1.05 (0.91-1.21)
Radiotherapy/radiochemotherapy	1.48 (0.95-2.32)	1.22 (0.46-3.29)
Mixed	1.50 (0.62-3.66)	1.72 (0.67-4.41)
None	1.32 (1.06-1.65)	1.28 (1.01-1.63)
Overall	1.16 (1.05-1.29)	1.11 (0.99-1.25)
LR test	0.2715	0.4088

Sensitivity analysis for on study mortality: studies designed for long-term follow-up.

Twenty four studies (Hedenus 2003; Smith 2008; Pirker 2008; Vansteenkiste 2002; Aapro 2008; Untch 2008; Goss 2005; Chang 2005; EPO-GBR-7; Debus 2006; Thomas 2008; Littlewood 2001; Milroy 2003; Thomas 2002; Leyland-Jones 2003; Pronzato 2002; Henke 2003; Osterborg 2002; Strauss 2008; Moebus 2007; Grote 2005; OBE/EPO-INT-03; Savonije 2005; Machtay 2007) were designed for long-term follow-up, defined as follow-up of at least 12 months after treatment period. For a sensitivity analysis we restricted the on study mortality analysis to these studies, for results see below. There is an apparent change in the chemotherapy group; however, the confidence intervals are widely overlapping.

Table 10: Sensitivity analyses for on study mortality in all cancer patients at study level

Two-stage meta-analysis based on random-effects Cox model	Including all studies	Including only studies designed for long-term follow-up
ESA versus control	HR (95% CI)	HR (95% CI)
Chemotherapy	1.09 (0.97-1.23)	1.19 (1.03-1.37)
Radiochemotherapy	1.47 (0.83-2.59)	1.47 (0.83-2.59)
Radiotherapy	1.51 (0.73-3.12)	1.51 (0.72-3.12)
Mixed	1.50 (0.62-3.66)	-
None	1.32 (1.06-1.65)	1.37 (1.05-1.78)
Overall	1.16 (1.05-1.29)	1.24 (1.10-1.41)
LR test	0.4234	0.6638

Sensitivity analysis for on study mortality chemotherapy population

Sensitivity analysis for on study mortality chemotherapy population patients truly receiving chemotherapy at individual patient level

We analyzed whether the mortality signal seen in the chemotherapy population can be explained by patients in these studies not receiving chemotherapy. For this analysis we included all patients from the chemotherapy trials and restricted the analysis to those patients who did receive chemotherapy as reported in the data set provided. Patients who did not receive chemotherapy and patients without reported data whether or not they received chemotherapy were excluded from the analysis. In the next step we restricted the analysis to patients who truly received chemotherapy and received at least one dose of ESA in the active arm and zero doses of ESA in the control arm, for results see table below. We then included stepwise patients from the treatment populations “mixed” and “radiochemotherapy” and restricted the analyses stepwise as outlined above, for results see below.

Table 11: Sensitivity analyses for on study mortality in chemotherapy patients

Two-stage meta-analysis based on random-effects Cox model	ESA versus control	P value	N included
	HR (95% CI)		
Chemotherapy trials			
Analysis restricted to studies reporting chemotherapy status of each patient during ESA study	1.08 (0.95-1.24)	0.242	8732
Analysis restricted to patients who actually received chemotherapy (subsets included: “chemotherapy”)	1.10 (0.96-1.27)	0.172	8481
Analysis restricted to patients who actually received chemotherapy AND ESA in active arm AND no ESA in control arm (subsets included: “chemotherapy”)	1.09 (0.94-1.26)	0.257	8114
Chemotherapy and mixed trials			
Analysis restricted to studies reporting chemotherapy status of each patient during ESA study	1.09 (0.96-1.25)	0.199	8998
Analysis restricted to patients who actually received chemotherapy (subsets included: “chemotherapy” and “mixed”)	1.12 (0.97-1.28)	0.112	8651
Analysis restricted to patients who actually received chemotherapy AND ESA in active arm AND no ESA in control arm (subsets included: “chemotherapy” and “mixed”)	1.10 (0.96-1.27)	0.173	8284
Chemotherapy, mixed and radiochemotherapy trials			
Analysis restricted to studies reporting chemotherapy status of each patient during ESA study	1.11 (0.96-1.27)	0.153	9661
Analysis restricted to patients who actually received chemotherapy (subsets: “chemotherapy”, “mixed” and “radiochemotherapy”)	1.14 (1.00-1.30)	0.051	9307
Analysis restricted to patients who actually received chemotherapy AND ESA in active arm AND no ESA in control arm (subsets included: “chemotherapy”, “mixed” and “radiochemotherapy”)	1.12 (0.98-1.28)	0.101	8919

Overall the effect of ESA on patients receiving chemotherapy did not change, i.e. the effect estimate did not decrease. Therefore it is unlikely that the observed effect of ESA in the subset chemotherapy treatment population can be explained by events in patients who did not receive chemotherapy.

Studies with prespecified chemotherapy protocols at study level

Of the 38 studies classified as chemotherapy trial, in three studies ([Untch 2008](#); [Moebus 2007](#); [EPO-GER-20](#)) a detailed protocol that specified the substance, dosage, timing and frequency of chemotherapy was part of the ESA study. We compared the results of these studies with chemotherapy studies where the chemotherapy modalities were not specified in detail, for results see below. Of note: in two ([Untch 2008](#); [Moebus 2007](#)) of the studies with prespecified chemotherapy protocols, no patient died during on study treatment phase. Overall, there was no evidence for a difference between studies with and without prespecified study protocol.

Table 12: Sensitivity analysis for on study mortality in chemotherapy patients

Two-stage meta-analysis based on random-effects Cox model	ESA versus control
	HR (95% CI)
Chemotherapy with prespecified chemotherapy protocol*	0.61 (0.211-1.76)
Chemotherapy without prespecified chemotherapy protocol	1.10 (0.97-1.24)
Overall	1.09 (0.97-1.23)
LR test	0.2702

*Only one study included ([EPO-GER-20](#))

Table 13: Sensitivity analysis for overall survival in chemotherapy patients

Two-stage meta-analysis based on random-effects Cox model	ESA versus control
	HR (95% CI)
Chemotherapy with prespecified chemotherapy protocol*	1.11 (0.861-1.45)
Chemotherapy without prespecified chemotherapy protocol	1.03 (0.96-1.10)
Overall	1.04 (0.97-1.11)
LR test	0.5937

*Three studies included ([Untch 2008](#); [Moebus 2007](#); [EPO-GER-20](#))

Sensitivity analyses for radiotherapy population

Studies with prespecified radiotherapy protocols at study level

Of the eight studies classified as radiotherapy and radiochemotherapy population, in one radiotherapy study ([Machtay 2007](#)) and in three radiochemotherapy studies ([Thomas 2008](#); [Debus 2006](#); [Strauss 2008](#)) a detailed anti-cancer treatment protocol was part of the ESA study. We compared the results of these studies with radiotherapy/radiochemotherapy studies where the treatment modalities were not specified in detail. There was no evidence for a difference between these two subsets of studies, for results see below.

Table 14: Sensitivity analysis for on study mortality in radiotherapy patients at study level

Two-stage meta-analysis based on random-effects Cox model	ESA versus control
	HR (95% CI)
Radiotherapy/radiochemotherapy with prespecified treatment protocol	1.39 (0.812.40)
Radiotherapy/radiochemotherapy without prespecified treatment protocol	1.69 (0.773.73)
Overall	1.48 (0.95-2.32)
LR test	0.6233

Table 15: Sensitivity analysis for overall survival in radiotherapy patients at study level

Two-stage meta-analysis based on random-effects Cox model	ESA versus control
	HR (95% CI)
Radiotherapy/radiochemotherapy with prespecified treatment protocol	1.05 (0.751.46)
Radiotherapy/radiochemotherapy without prespecified treatment protocol	1.16 (0.951.41)
Overall	1.06 (0.90-1.26)
LR test	0.1051

Sensitivity analyses for overall survival

Sensitivity analysis for overall survival: studies designed for long-term follow-up.

Twenty four studies (Hedenus 2003; Smith 2008; Pirker 2008; Vansteenkiste 2002; Aapro 2008; Untch 2008; Goss 2005; Chang 2005; EPO-GBR-7; Debus 2006; Thomas 2008; Littlewood 2001; Milroy 2003; Thomas 2002; Leyland-Jones 2003; Pronzato 2002; Henke 2003; Osterborg 2002; Strauss 2008; Moebus 2007; Grote 2005; OBE/EPO-INT-03; Savonije 2005; Machtay 2007) were designed for long-term follow-up, defined as follow-up of at least 12 months after treatment period. For a sensitivity analysis we restricted overall survival to these studies, for results see below. Overall, the results did not change.

Table 16: Sensitivity analysis for overall survival in all cancer patients: studies designed for long-term follow-up

Two-stage meta-analysis based on random-effects Cox model	Including all studies	Including only studies designed for long-term follow-up
ESA versus control	HR (95% CI)	HR (95% CI)
Chemotherapy	1.04 (0.97-1.11)	1.06 (0.97-1.15)
Radiochemotherapy	0.98 (0.75-1.27)	1.02 (0.74-1.41)
Radiotherapy	1.17 (0.96-1.42)	1.17 (0.96-1.42)

(Continued)

Mixed	1.50 (0.62-3.66)	-
None	1.22 (1.04-1.44)	1.22 (1.02-1.47)
Overall	1.06 (1.00-1.12)	1.07 (0.99-1.15)
LR test	0.11	0.1240

Sensitivity analysis for overall survival: exclusion of studies terminated prematurely

Fourteen studies were terminated prematurely (Charu 2007; CC2574-P-174; Quirt 1996; Goss 2005; Wright 2007; EPO-GBR-7; EPO-GER-20; Debus 2006; Thomas 2008; Leyland-Jones 2003; Grote 2005; OBE/EPO-INT-03; Vadhan-Raj 2004; Machtay 2007), for a sensitivity analysis we excluded these studies from the analysis, for results see below. Exclusion of these studies did not affect the overall effect estimate.

Table 17: Sensitivity analysis for overall survival in all cancer patients

Two-stage meta-analysis based on random-effects Cox model	Including prematurely stopped studies	Excluding prematurely stopped studies
ESA versus control	HR (95% CI)	HR (95% CI)
Chemotherapy	1.04 (0.97-1.11)	1.01 (0.94-1.08)
Radiochemotherapy	0.98 (0.75-1.27)	2.00 (0.65-6.15)
Radiotherapy	1.17 (0.96-1.42)	1.27 (0.96-1.69)
Mixed	1.50 (0.62-3.66)	1.72 (0.67-4.41)
None	1.22 (1.04-1.44)	1.19 (1.00-1.42)
Overall	1.06 (1.00-1.12)	1.05 (0.98-1.42)
LR test	0.11	0.1128

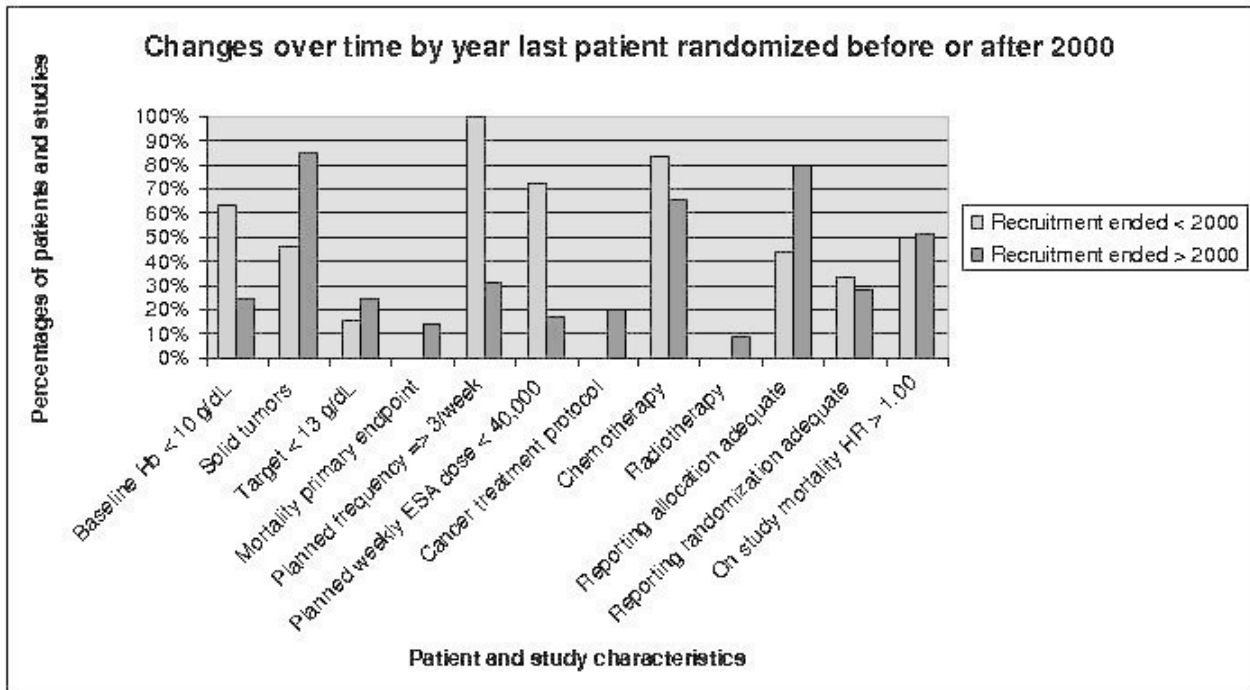
Appendix 4. Exploratory analyses

Analyses that were not planned at the protocol stage are listed in this section.

Characteristics of studies included: changes over time

We evaluated changes over time of the characteristics of the included studies based on the year when the last patient was randomized into the respective study. Cut off for this binary comparison was last patient randomized before (early studies) or after 2000 (later studies). Patients in early studies were more likely to have Hb baseline < 10 g/dL (63% versus 25%) and less likely to have solid tumors (46% versus 85%). None of the early studies evaluated survival as primary endpoint and none included a stringent anticancer therapy protocol. All (100%) of the early studies applied ESA three times per week or more often compared to 31% of the more recent studies. Early studies used more likely to use chemotherapies (83% versus 66%) and no radiotherapy (0% versus 9%). Reporting of the study methods changed over time: while reporting of concealment of allocation improved over time (42% adequate in the early and 76% adequate in the late studies); reporting of randomization procedures did not improve (adequate in 42% of the early studies and 27% in the late studies). Although the study designs changed over time, the observed hazard ratios for on study mortality did not change, i.e. the percentage of studies reporting increased mortality (HR => 1.0) was identical in the early and the more recent studies (50% versus 51%), see [Figure 18](#).

Figure 18. Comparing studies with last patient randomized before 2000 or after 2000



Exploratory analysis: Kaplan-Meier curves for all endpoints

Kaplan-Meier survival curves for all four outcomes are presented below. For these curves patient data were pooled without stratification for study, see [Figure 19](#), [Figure 20](#), [Figure 21](#) and [Figure 22](#).

Figure 19. Pooled Kaplan Meier plot for on study mortality in all cancer patients

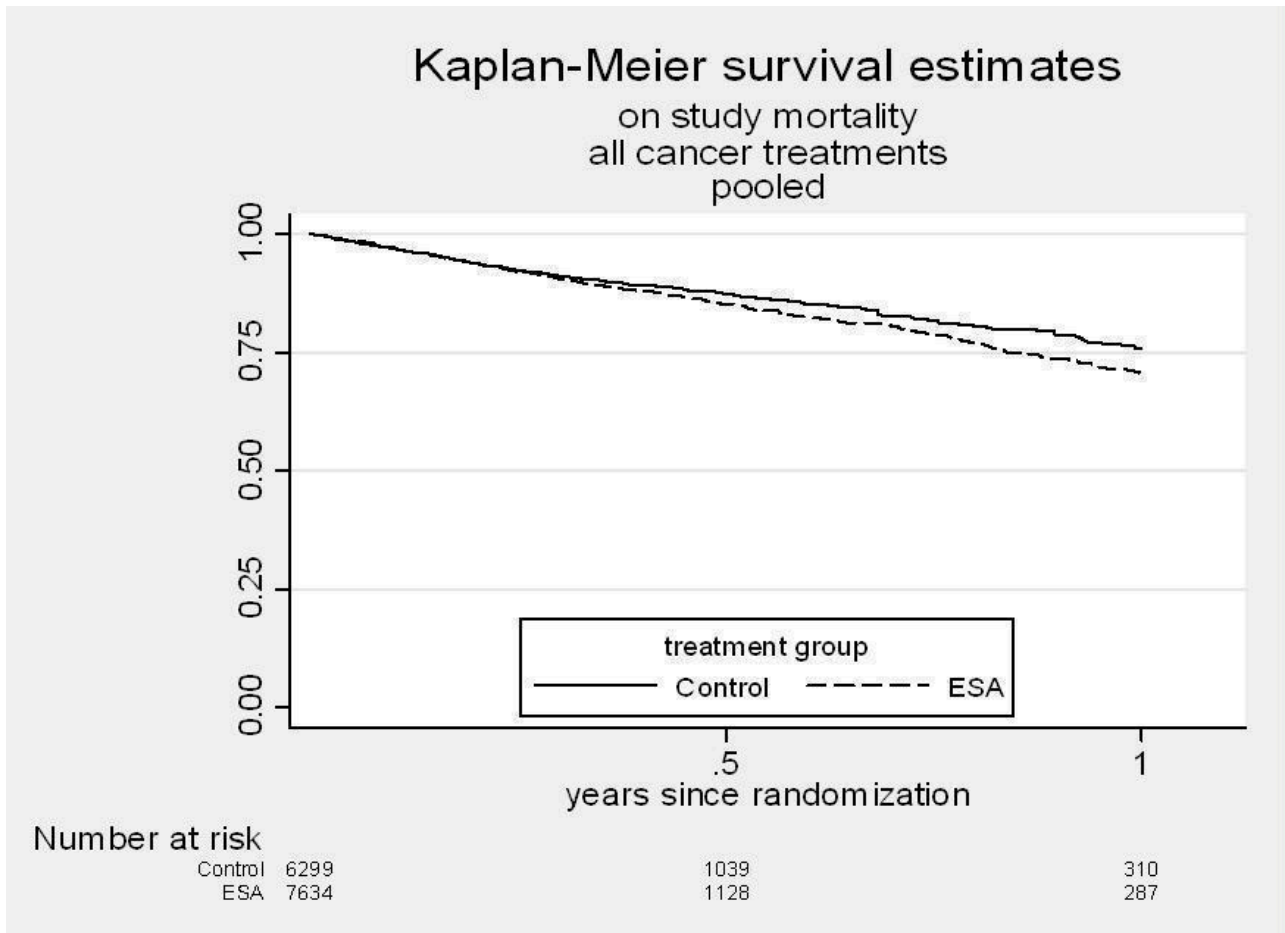


Figure 20. Pooled Kaplan Meier plot for on study mortality in chemotherapy patients

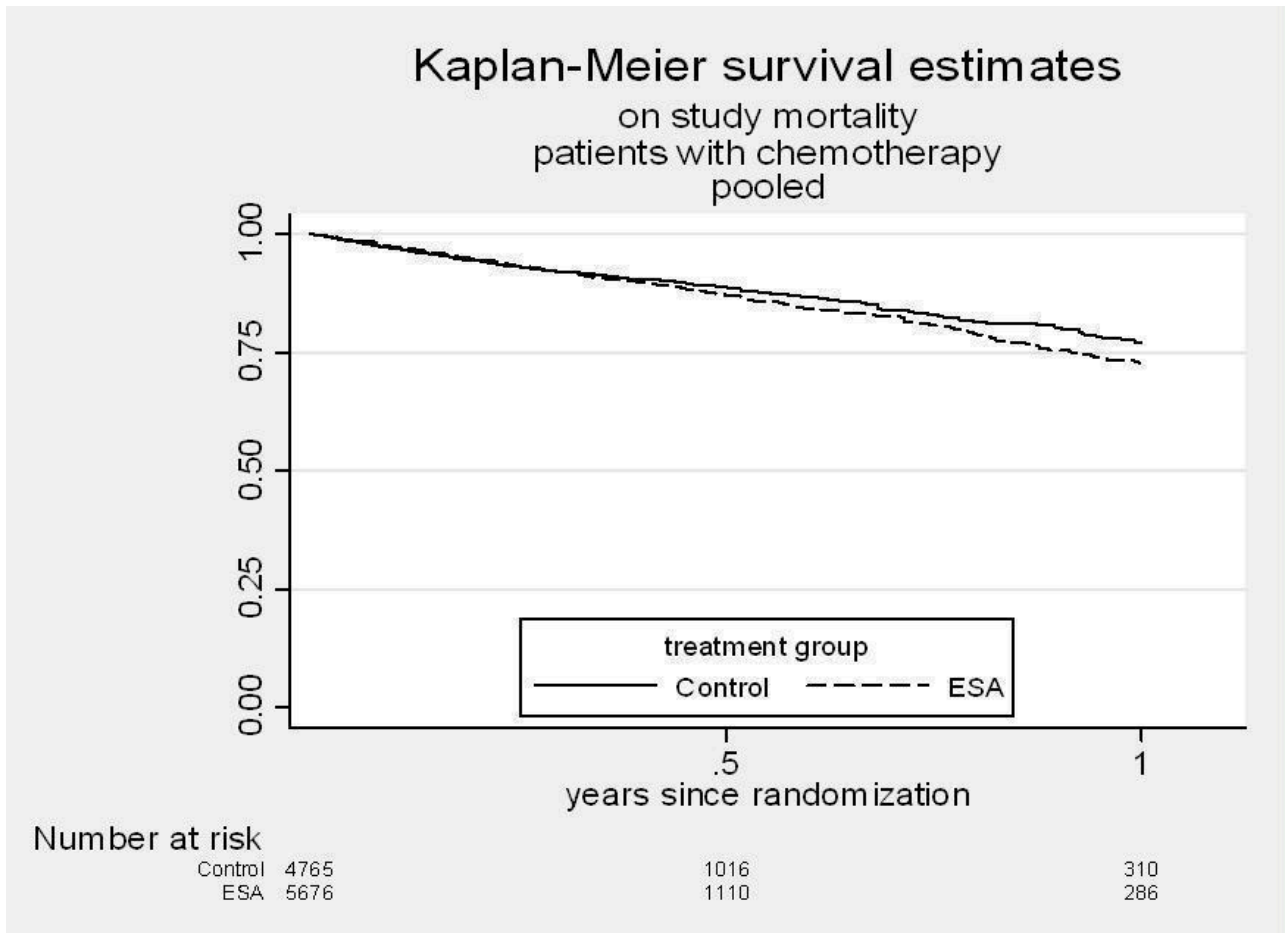


Figure 21. Pooled Kaplan Meier plot for overall survival in all cancer trials

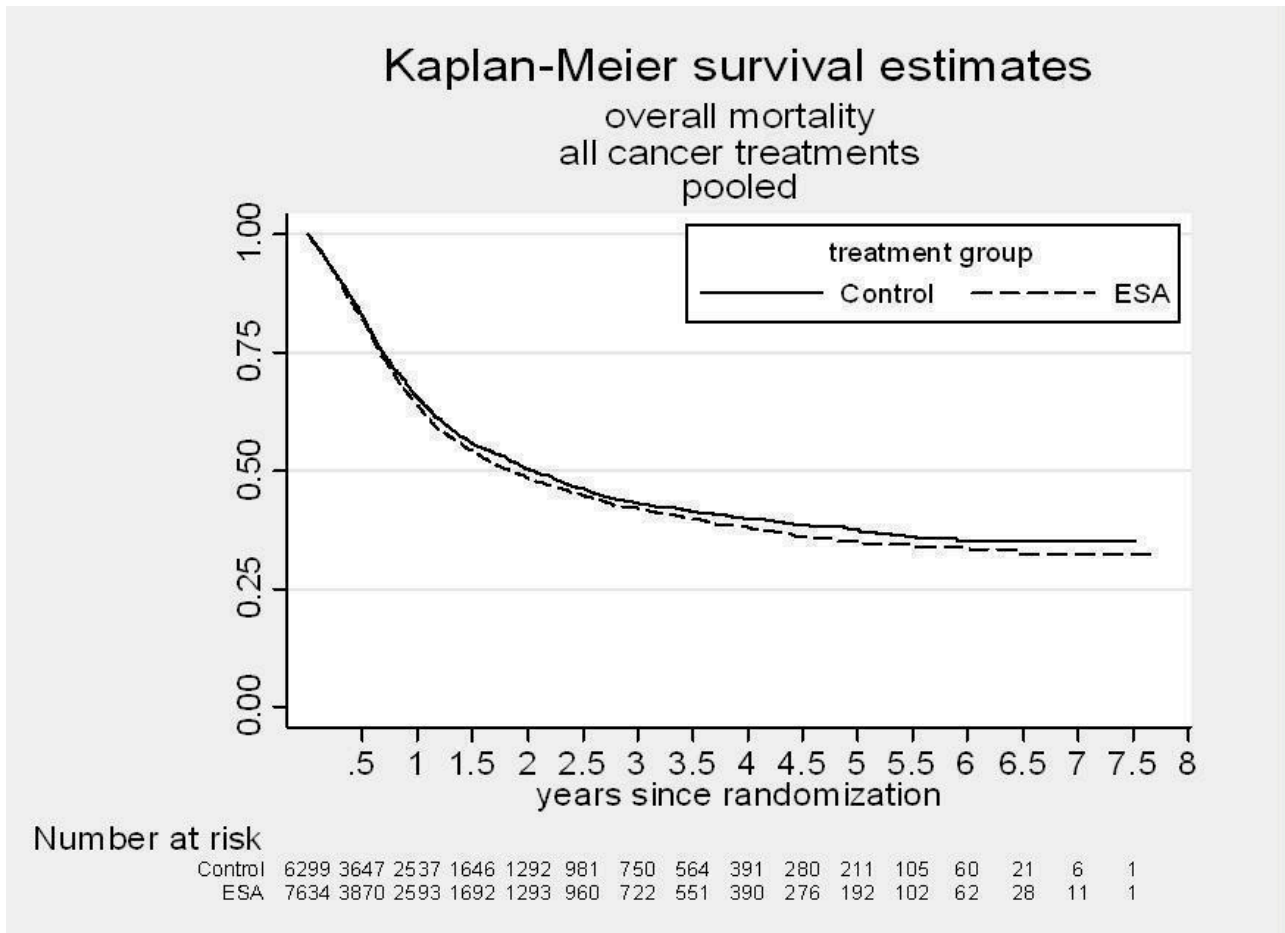
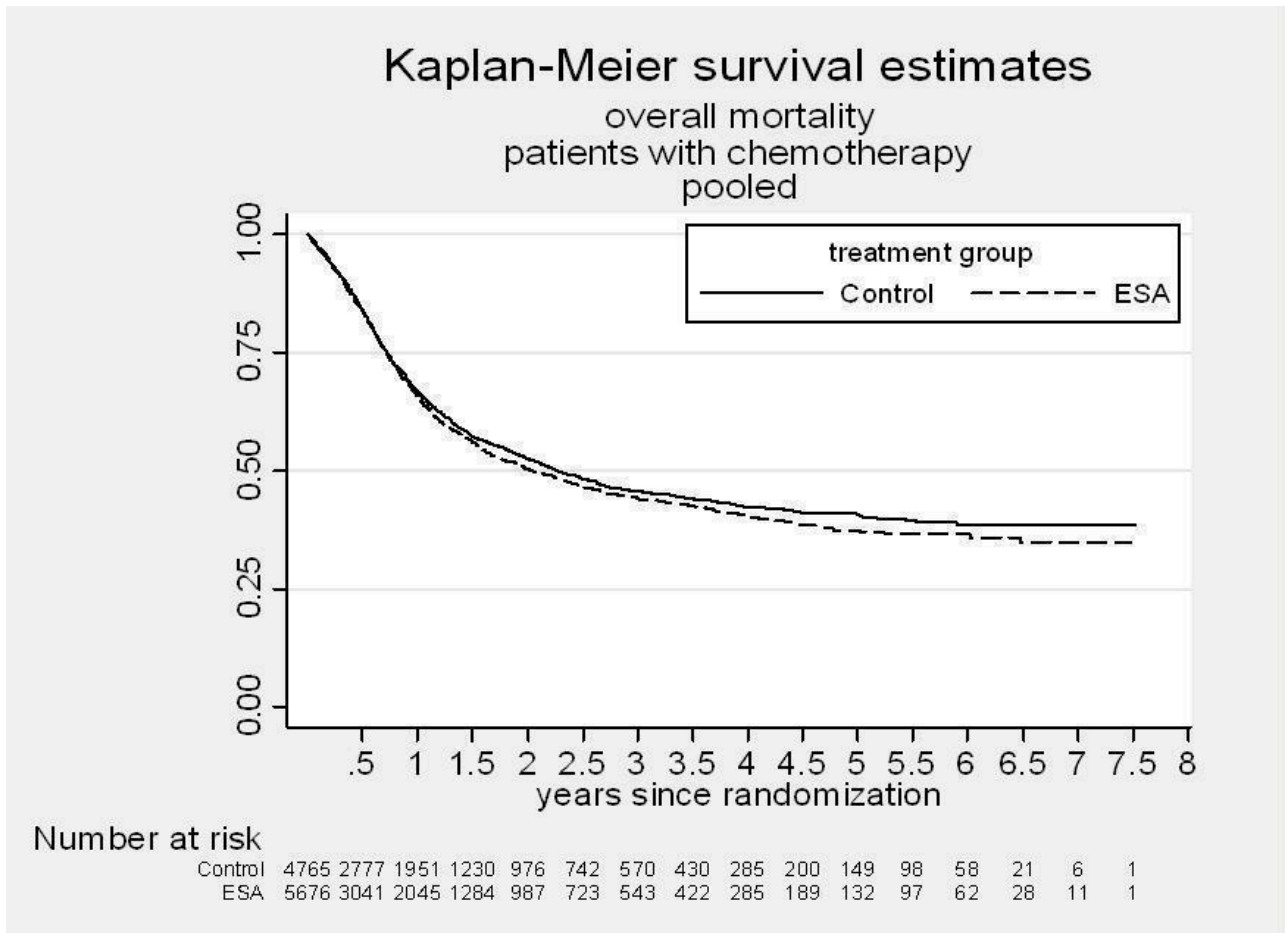


Figure 22. Pooled Kaplan Meier plot for overall survival in chemotherapy trials (subset analysis)



Exploratory analyses of interaction terms for on study mortality, all cancer patients

History of thromboembolic events

In the analysis of on study mortality in all cancer patients, patients with a history of thromboembolic events were less likely to die when receiving ESAs (HR 0.80, 95% CI 0.52-1.23) compared to patients without a previous thromboembolic event and receiving ESAs (HR 1.23, 95% CI 1.09-1.39, test for interaction: 0.0605). The effect remained after adjusting for sex, age, Hb at baseline and tumor type (P value for interaction = 0.0440), see table below. History of thromboembolic events was more often recorded in more recent studies (46% missing in studies with last patient randomized before 2000 versus 27% in the more recent studies). Patients with a history of thromboembolic events had more often a poor ECOG performance status (12% versus 6%) and high serum EPO levels (7% versus 3% serum EPO > 500) compared to patients without a positive history of thromboembolic events. There was no difference with respect to percentage of patients with metastatic disease. When adjusting for age, sex, Hb at baseline, tumor type and in addition ECOG and serum EPO level the observed effect became more pronounced, see table below. However, only 7999 out of 13933 (57%) and 4281 (31%) of patients were included in these analyses; others were excluded because of missing data. Therefore, a selection bias cannot be excluded.

Table 1: Assessment of history of thromboembolic events and effect modification, on study mortality in all cancer patients

On study mortality all cancer patients	Bivariate ESA versus control			Multivariate ESA versus control			Multivariate ESA versus control			Multivariate ESA versus control		
Interaction term	ESA*HTX			ESA*HTX			ESA*HTX			ESA*HTX		
Model adjusted for	-			age, sex, Hb, tumor type			age, sex, Hb, tumor type and ECOG			age, sex, Hb, tumor type and serum EPO		
Patients included	n = 9620			n = 9467			n = 7999			n = 4281		
	HR	95% CI	P*	HR	95% CI	P*	HR	95% CI	P*	HR	95% CI	P*
History of thromboembolic events (HTX)												
Yes	0.80	0.52-1.23	0.0605	0.77	0.50-1.19	0.0440	0.75	0.48-1.18	0.0338	0.48	0.25-0.93	0.0129
No	1.23	1.09-1.39		1.22	1.08-1.38		1.25	1.10-1.42		1.13	0.94-1.34	
<i>Missing / not reported</i>	<i>1.09</i>	<i>0.87-1.35</i>	<i>-</i>	<i>omitted</i>	<i>omitted</i>	<i>-</i>	<i>omitted</i>	<i>omitted</i>	<i>-</i>	<i>omitted</i>	<i>omitted</i>	<i>-</i>
Overall, unadjusted	1.20	1.07-1.34	-	1.20	1.07-1.34	-	1.21	1.07-1.36	-	1.10	0.93-1.30	-

*P value from LR test, patients with missing values were excluded from tests for interactions

Hematocrit at baseline

In the analysis of on study mortality in all cancer patients, there was some evidence that patients with a very low hematocrit at baseline (< 23.5%) had an increased risk to die compared to patients with higher hematocrit levels at baseline. Compared to patients with Hct above 23.5% at baseline, patients with low Hct had more often metastatic disease (89% versus 79%), were more often aged > 65 years (44% versus 40%) and had more often a poor ECOG performance status (4.7% versus 1.7%). Patients with low Hct values at baseline had also low Hb values and there was a correlation between Hct and Hb at baseline (correlation coefficient 0.8335). Hct data were missing for 21% of patients of the total population. In studies which recruited until 2000 (year last patient randomized) data were missing for only 8% of patients whereas for 24% of patients in the more recent studies Hct at baseline was not recorded.

After adjusting for age, sex, Hb at baseline and tumor type the effect remained, see table below. When in addition tumor stage was included in the multivariate model the effect of Hct on mortality was attenuated and the interaction test was not statistically significant. When ECOG performance status was included the effect of low Hct increased and the test for interaction was statistically significant. However, since only 9714 (70%) and 7686 (55%) of the total patient population was included in these analyses, the power for statistical tests was reduced and a selection bias cannot be excluded. For results see table below.

Table 2: Assessment of additional factors for hematocrit and interaction, on study mortality all cancer patients

On study mortality all cancer patients	Bivariate ESA versus control HCT*ESA			Multivariate ESA versus control HCT*ESA			Multivariate ESA versus control HCT*ESA			Multivariate ESA versus control HCT*ESA		
Adjusted for	-			age, sex, Hb, tumor type			age, sex, Hb, tumor type and tumor stage			age, sex, Hb, tumor type and ECOG		
Patients included	n = 11036			n = 10972			n = 9714			n = 7686		
	HR	95% CI	P*	HR	95% CI	P*	HR	95% CI	P*	HR	95% CI	P*
Hct at baseline												
< 23.5%	2.19	1.35-3.55	0.0110	2.13	1.30-3.48	0.0191	1.92	1.13-3.24	0.1220	2.85	1.47-5.53	0.0254
23.5-29.4%	0.96	0.78-1.17		0.96	0.79-1.18		1.00	0.80-1.24		1.00	0.80-1.26	
29.4-35.3%	1.17	0.99-1.39		1.15	0.97-1.37		1.23	1.02-1.48		1.17	0.96-1.42	
35.3-41.2%	1.41	1.12-1.76		1.39	1.10-1.74		1.37	1.08-1.72		1.39	1.07-1.79	
> 41.2%	1.12	0.73-1.70		1.15	0.76-1.76		1.15	0.75-1.75		1.15	0.71-1.89	
Missing	1.09	0.76-1.55	-	omitted		-	omitted		-	omitted		-
Overall, unadjusted	1.18	1.06-1.32	-	1.18	1.06-1.32	-	1.22	1.09-1.36	-	1.20	1.06-1.35	-

*P value LR test, missing data were excluded from LR tests

Planned frequency of ESA application

In the analysis of on study mortality in all cancer patients there was some evidence for an effect modification of planned frequency of ESA application and on study mortality in all cancer patients, i.e. patients receiving ESAs three times per week or more frequently were less likely to die compared to patients receiving ESAs only once or less often per week. This effect remained after adjusting for age, sex, Hb and tumor type. However, other aspects of study design were associated with the planned frequency of ESA application. Studies in which ESA was applied three times per week (TIW) or more often had lower average starting doses of ESAs (62% of TIW studies with ESA starting dose < 40000 per week). TIW studies were older, i.e. 63% of TIW studies randomized patients prior to calendar year 2000, whereas none of the studies that administered ESA QW or less frequently had completed randomization before 2000. In none of the TIW studies survival was assessed as primary endpoint. There were no major differences with regard to underlying chemotherapy, i.e. percentage of studies on chemotherapy, radiotherapy or no therapy was distributed equally across different application frequencies; the same applies to the planned duration of the ESA treatment. In meta-regression analyses these factors were explored, for results see table next page. Analyses were based both on unadjusted and adjusted HRs stemming from the 53 included studies.

Table 3a: Meta-regression analysis for planned frequency based on unadjusted hazard ratios for individual studies

On study mortality all cancer patients	Meta-regression ESA versus con- trol		Meta-regression ESA versus control		Meta-regression ESA versus control		Meta-regression ESA versus control		Meta-regression ESA versus control	
Additional included variable(s)	endpoint		planned weekly ESA dose		year last patient randomized		endpoint and planned weekly dose		last patient randomized, endpoint and planned weekly dose	
HR of studies adjusted for	-		-		-		-		-	
Studies included	n = 53		n = 53		n = 53		n = 53		n = 53	
Planned frequency of ESA application	HR	95% CI	HR	95% CI	HR	95% CI	HR	95% CI	HR	95% CI
Three times per week or more frequent	1.09	0.76-1.58	0.92	0.75-1.14	0.94	0.68-1.29	1.05	0.73-1.53	1.00	0.60-1.66
Once per week	1.44	1.17-1.77	1.26	0.86-1.84	1.19	0.76-1.88	1.27	0.85-1.89	1.19	0.63-2.23
Every second week or less frequent	0.93	0.50-1.73	0.94	0.59-1.52	0.90	0.49-1.64	0.80	0.39-1.62	0.75	0.29-1.93
Other	0.96	0.67-1.33	0.71	0.44-1.76	0.65	0.33-1.31	0.77	0.47-1.27	0.79	0.33-1.91
Test for differences between subgroups*	p = 0.0669		p = 0.1196		p = 0.0940		p = 0.1560		p = 0.4270	

***P value for test for differences between subgroups from meta-regression (Wald test)**

Table 3b: Meta-regression analysis for planned frequency based on adjusted hazard ratios for individual studies

On study mortality all cancer patients	Meta-regression ESA versus control		Meta-regression ESA versus control		Meta-regression ESA versus control		Meta-regression ESA versus control		Meta-regression ESA versus control	
Additional included variable(s)	endpoint		planned weekly ESA dose		last patient randomized		endpoint and planned weekly dose		year last patient randomized, endpoint and planned weekly dose	
HR of studies adjusted for	Age, sex, Hb, tumor type		Age, sex, Hb, tumor type		Age, sex, Hb, tumor type		Age, sex, Hb, tumor type		Age, sex, Hb, tumor type	
Studies included	n = 53		n = 53		n = 53		n = 53		n = 53	
Planned frequency of ESA application	HR	95% CI	HR	95% CI	HR	95% CI	HR	95% CI	HR	95% CI
Three times per week or more frequent	1.14	0.78-1.67	0.93	0.74-1.17	0.99	0.69-1.41	1.08	0.74-1.59	0.97	0.57-1.68
Once per week	1.46	1.18-1.80	1.34	0.91-1.99	1.17	0.72-1.91	1.39	0.92-2.09	1.16	0.60-2.26
Every second week or less frequent	0.88	0.46-1.67	0.92	0.56-1.50	0.87	0.46-1.65	0.80	0.38-1.66	0.67	0.25-1.80
Other	0.91	0.64-1.29	0.67	0.40-1.10	0.64	0.31-1.33	0.72	0.43-1.20	0.72	0.29-1.83
Test for differences between subgroups*	p = 0.0424		p = 0.0363		p = 0.1668		p = 0.0423		p = 0.3000	

P value for test for differences between subgroups from meta-regression (Wald test)*Exploratory analyses of interaction terms for overall survival, chemotherapy trials**

In the overall survival analysis in chemotherapy trials, sex showed a statistically significant interaction term in the bivariate analysis. Women were at increased risk to die when receiving ESAs (HR 1.10, 95% CI 1.01-1.21) compared to men (HR 0.96, 95% CI 0.87-1.06, P value for interaction: 0.0370). When adjusting in addition for age, Hb at baseline and tumor category, the modifying effect for sex remained (P value for interaction 0.0362). A potential explanation for this finding is the large number of female patients with breast cancer included in the analysis. I.e. of the 9892 patients included in the multivariate model testing for interaction, 4303 (43%) patients were diagnosed with breast cancer, of which 1998 (46%) had metastatic disease. When patients with breast cancer were removed from the analysis, the modifying effect of sex on overall survival in chemotherapy patients was attenuated (P value LR test model with & without interaction term for sex excluding breast cancer patients = 0.1571). In the next steps we also excluded patients with a) gynecological cancers and b) prostate and testicular cancer, restricting the analysis to cancers that can occur both in male and female patients. The effect of sex was further attenuated and the test statistic was not significant, however, 63% of the patient population was excluded from the analysis with this strategy. In none of the analyses the modifying effect of sex on survival disappeared completely, however, the differences observed were small.

Table 4: Overall survival in chemotherapy trials, tests for interaction, univariate and multivariate models

Overall survival in chemotherapy trials	Bivariate ESA versus control			Multivariate ESA versus control			Multivariate ESA versus control			Multivariate ESA versus control			Multivariate ESA versus control		
Interaction term	ESA*sex			ESA*sex			ESA*sex			ESA*sex			ESA*sex		
Adjusted for	-			age, sex, Hb, tumor type			age, sex, Hb, tumor type			age, sex, Hb, tumor type			age, sex, Hb, tumor type		
Patients excluded	-			-			excluding breast cancer patients			excluding breast cancer and gynecological cancer patients			excluding breast cancer, gynecological cancer as well as prostate and testicular cancer patients		
Patients included	n = 10441			n = 9892			n = 6257			n = 5205			5128		
ESA versus control	HR	95% CI	P*	HR	95% CI	P*	HR	95% CI	P*	HR	95% CI	P*	HR	95% CI	P*
Sex															
Male	0.96	0.87-1.06	0.037	0.97	0.87-1.07	0.036	0.97	0.87-1.07	0.157	0.97	0.87-1.07	0.207	0.97	0.87-1.07	0.216
Female	1.10	1.01-1.21	-	1.12	1.02-1.22	-	1.09	0.96-1.23	-	1.07	0.94-1.23	-	1.07	0.94-1.23	-
Overall result, unadjusted	1.04	0.97-1.11	-	1.04	0.97-1.11	-	1.00	0.93-1.08	-	1.00	0.91-1.07	-	0.99	0.92-1.08	-

*P value LR test comparing model with & without interaction term

Exploratory analysis for Hb change over time at study level in control arm

In this analysis we assessed the influence of myelosuppressive anticancer treatments. The only measures for myelosuppression available were Hb values in the control arm over time. Other laboratory values, such as platelets, were not requested for the present analysis. For each study we assessed whether the Hb decreased over time or not by plotting the Hb of the control arm of each study over time. Studies with Hb decrease of > 1 g/dL from baseline within 50 days were categorized as “Hb decrease”, studies with Hb within +1 g/dL to 1 g/dL margin from baseline within 50 days were categorized as “no change”. Studies with an Hb increase > 1 g/dL from baseline within 50 days were categorized as “Hb increase”. We further differentiated whether the baseline Hb of the respective study was < 10 g/dL, 10-12 g/dL or > 12 g/dL at baseline. Please note: the classification of the studies was made at study level; the Hb curve of an individual patient was not assessed. All studies regardless of treatment population category were included in this analysis. Hb over time is only a proxy for myelosuppression and red blood cell transfusions might confound the Hb levels over time. Overall, there is no evidence for a difference between the explored groups.

Table 5: Exploratory analysis for on study mortality in all cancer patients, Hb change in control arm

Two-stage meta-analysis based on random-effects Cox model	ESA versus control HR (95% CI)
Hb increase	1.18 (95% CI 0.70-1.98)
Hb no change	1.17 (95% CI 1.04-1.32)
Hb decrease	1.14 (95% CI 0.91-1.43)
Unclear/not reported	0.62 (95% CI 0.16-2.43)
Overall	1.16 (95% CI 1.05-1.29)
LR test	0.8154

Table 6: Exploratory analysis for on study mortality in all cancer patients, Hb change in control arm

Two-stage meta-analysis based on random-effects Cox model	ESA versus control HR (95% CI)
Baseline Hb < 10 g/dL & Hb no change	1.08 (95% CI 0.90-1.30)
Baseline Hb < 10 g/dL & Hb increase	1.18 (95% CI 0.70-1.98)
Baseline Hb 10-12 g/dL & Hb decrease	1.02 (95% CI 0.70-1.50)
Baseline Hb 10-12 g/dL & Hb no change	1.13 (95% CI 0.91-1.40)
Baseline Hb > 12 g/dL & Hb decrease	1.21 (95% CI 0.91-1.61)
Baseline Hb > 12 g/dL & Hb no change	1.44 (95% CI 1.11-1.88)
Unclear/not reported	0.62 (95% CI 0.16-2.43)
Overall	1.16 (95% CI 1.05-1.29)

(Continued)

LR test 0.6180

Exploratory analysis for Hb change over time at study level in ESA arm

For this analysis the Hb change over time in the ESA arm for each study was plotted. Studies with an Hb increase of > 1 g/dL from baseline within 50 days were categorized as “increase”. Studies with Hb decrease of > 1 g/dL from baseline within 50 days were categorized as “decrease”, studies with Hb within +1 g/dL to 1 g/dL margin from baseline within 50 days were categorized as “no change”. We further differentiated whether the baseline Hb of the respective study was < 10 g/dL, 10-12 g/dL or > 12 g/dL in the ESA arm. Please note: the classification of the studies was made at study level; the Hb curve of an individual patient was not assessed. All studies regardless of treatment population category were included in this analysis. Overall, there is no evidence for a difference between the explored groups.

Table 7: Exploratory analysis for on study mortality in all cancer patients, Hb change in ESA arm at study level

Two-stage meta-analysis based on random-effects Cox model	ESA versus control HR (95% CI)
Hb increase	1.12 (95% CI 0.98-1.29)
Hb no change	1.23 (95% CI 1.05-1.44)
Hb decrease	1.04 (95% CI 0.48-2.24)
Unclear/not reported	0.62 (95% CI 0.16-2.43)
Overall	1.16 (95% CI 1.05-1.29)
LR test	0.7120

Table 8: Exploratory analysis for on study mortality in all cancer patients, Hb change in ESA arm at study level

Two-stage meta-analysis based on random-effects Cox model	ESA versus control HR (95% CI)
Baseline Hb < 10 g/dL & Hb no change	1.00 (95% CI 0.50-2.00)
Baseline Hb < 10 g/dL & Hb increase	1.07 (95% CI 0.88-1.30)
Baseline Hb 10-12 g/dL & Hb no change	1.17 (95% CI 0.83-1.64)
Baseline Hb 10-12 g/dL & Hb increase	1.10 (95% CI 0.84-1.46)
Baseline Hb > 12 g/dL & Hb decrease	1.04 (95% CI 0.48-2.24)
Baseline Hb > 12 g/dL & Hb no change	1.25 (95% CI 1.02-1.53)
Baseline Hb > 12 g/dL & Hb increase	1.93 (95% CI 0.66-5.67)
Unclear/not reported	0.62 (95% CI 0.16-2.43)
Overall	1.16 (95% CI 1.05-1.29)

(Continued)

LR test

0.8420

Exploratory analysis for longest follow-up available in studies with “cross-over”

In twelve studies patients in both the control and the active treatment arm were allowed to receive ESAs after a defined treatment period. For the main analysis we included only events and time under observation during this defined treatment period in the analysis. In the overall survival, which looked at the longest follow-up available, these studies were included only based on the events and the time period of the defined treatment period. For the purpose of a sensitivity analysis we included the longest follow-up of these studies for the overall survival analysis as well. The percentage of patients in both the control and the ESA arm who were receiving ESAs during the “cross-over” period, varied between studies. For details see tables below. When including cross-over trials based on the longest follow-up available the overall estimates were attenuated for both all cancer patients and chemotherapy trials. A cut off depending on a percentage of patients receiving ESAs was not applied in order to decide whether a specific study would be included in the analysis based on the on study or the longest follow-up estimate. These cut-offs were not applied because they had not been defined at the protocol stage and the percentage of patients receiving ESAs during open label phase was continuously increasing.

Table 9: Studies with “cross-over”: percentage of total study population receiving ESA during open-label phase

Studies with “cross-over”: percentage of total study population receiving ESA during open-label phase			
Study protocol	Study number	Total	Comment
CC2574-P-174	60584	93%	Data provided by company
J89-040	98358	81%	Data provided by company
EPO-INT-3/ CC 2574-P-034	36274	76%	Data provided by company
H87-032, 87-014/OEU-U20, 87-015/OEU-U21	98906	75%	Data provided by company
I88-037, 87-016, 87-017	34917	75%	Data provided by company
I88-036, 87-018, 87-019	70332	74%	Data provided by company
EPO-INT-2/ CC 2574-P-467	11220	60%	Data provided by company
20000219	53081	59%	Data from clinical study report
980291	35466	48%	Data from clinical study report
MF4321	45434	48%	Data from clinical study report
980291SCH2	26117	40%	Data from clinical study report
EPO-INT-76/EPO-CA-489	17100	24%	Data provided by company

Table 10: Sensitivity analyses including longest follow-up available for studies with “cross-over”

Two-stage log-rank fixed-effects meta-analysis	ESA versus control	P value	N included
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Erythropoietin or Darbepoetin for patients with cancer - meta-analysis based on individual patient data (Review)

160

(Continued)

HR (95% CI)

Overall survival, all cancer patients

Overall survival, all cancer patients, cross-over trials restricted to on study mortality	1.06 (1.00-1.12)	0.0561	13933
Overall survival, all cancer patients, cross-over trials included based on longest follow-up available	1.04 (0.98-1.09)	0.1719	13933

Overall survival, chemotherapy trials

Overall survival, chemotherapy trials, cross-over trials restricted to on study mortality	1.04 (0.97-1.11)	0.3081	10441
Overall survival, chemotherapy trials, cross-over trials included based on longest follow-up available	1.02 (0.96-1.08)	0.5743	10441

Exploratory analysis for current license indication

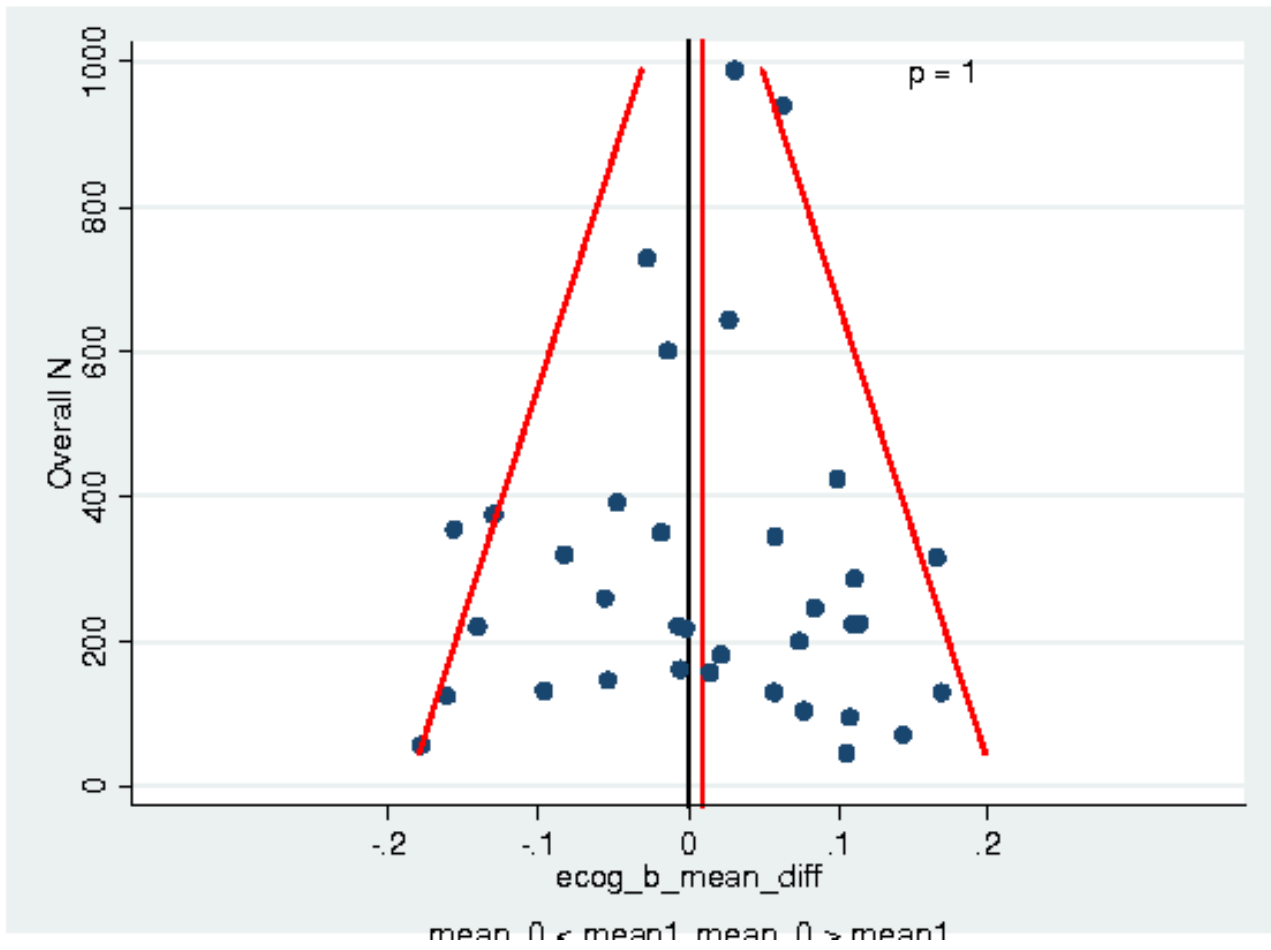
It is difficult to conduct an analysis that matches the current license indication. The main limitation is that the current indication recommends an Hb target of 12 g/dL. However, in none of the studies included in the present analysis the Hb ceiling was 12 g/dL or below. The next limitation is that the “current license indication” is an ever changing definition. Based on these considerations an analysis for the “current license indication” was not planned at the protocol for this meta-analysis (Bohlius 2008).

Appendix 5. Funnel plots Baseline imbalances

The following figures present funnel plots of baseline imbalances.

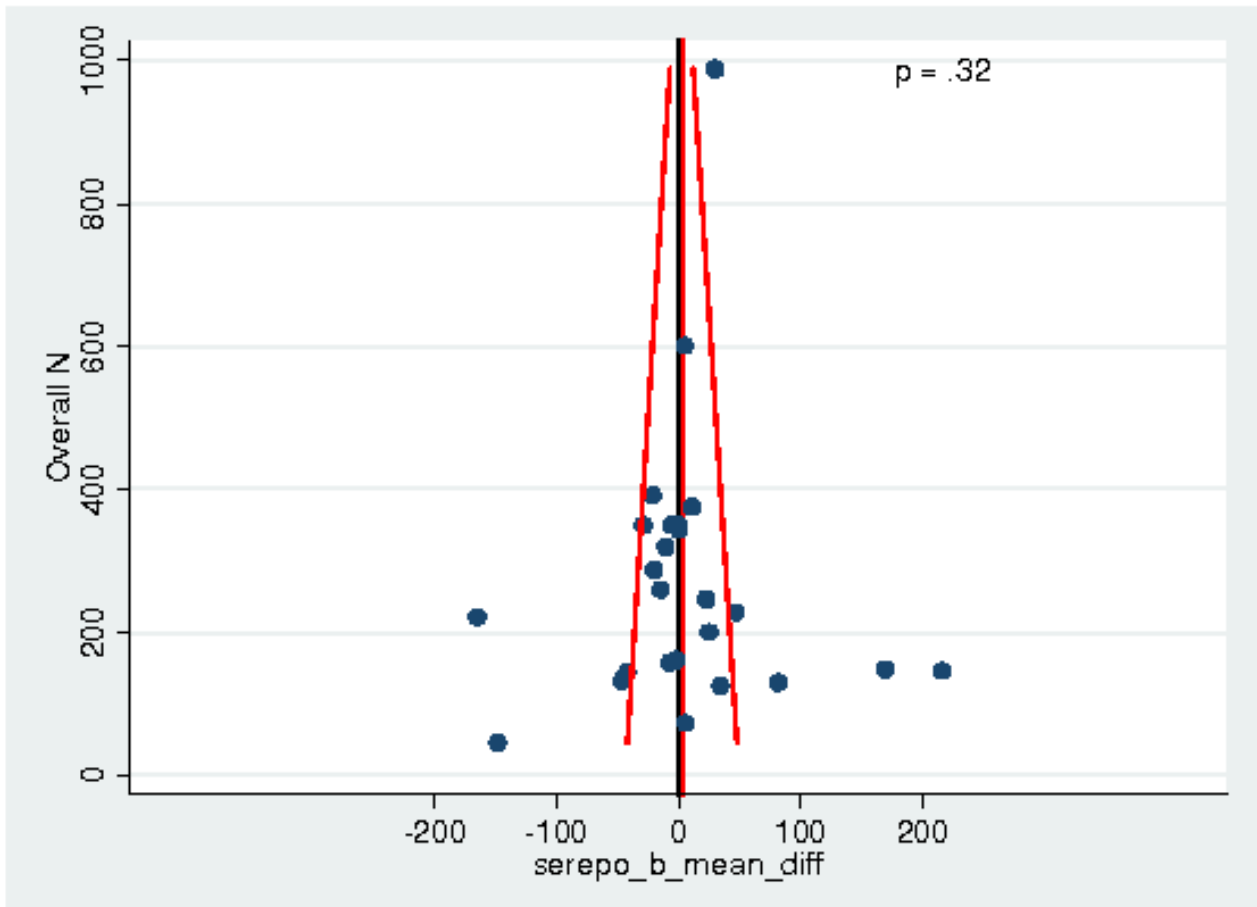
ECOG [Figure 23](#)

Figure 23. Baseline imbalances ECOG



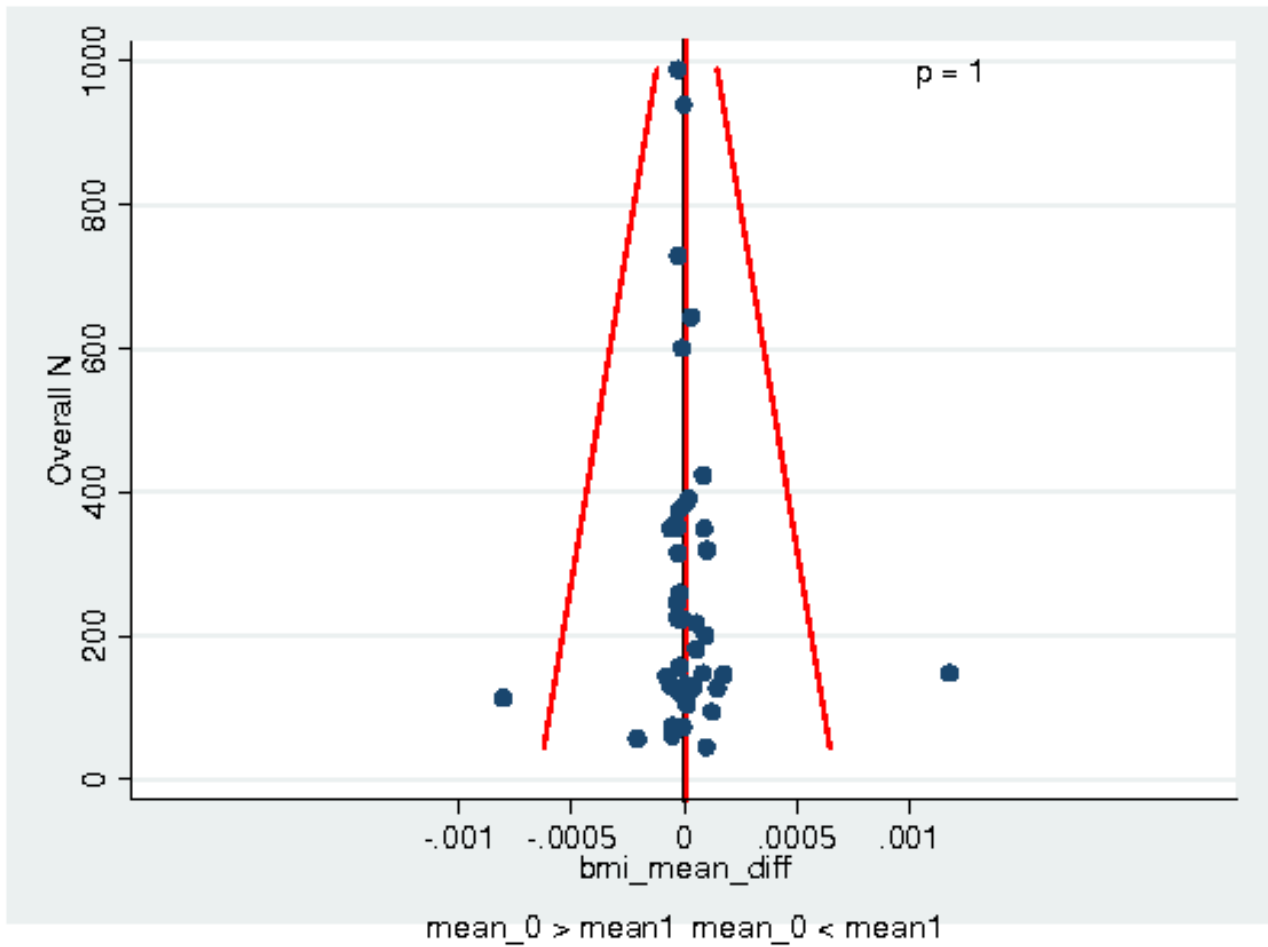
Level of EPO serum [Figure 24](#)

Figure 24. Level of EPO serum



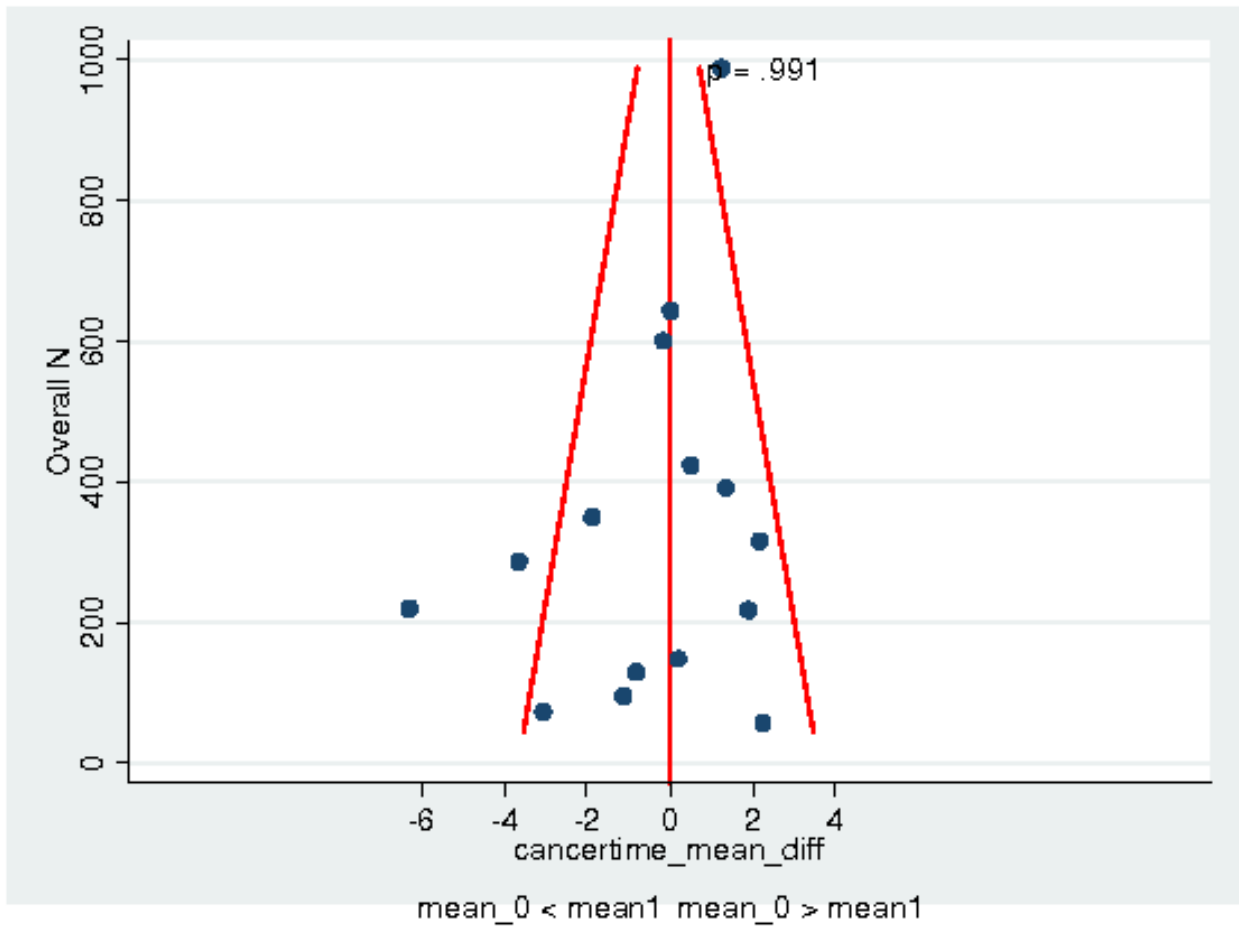
BMI Figure 25

Figure 25. BMI



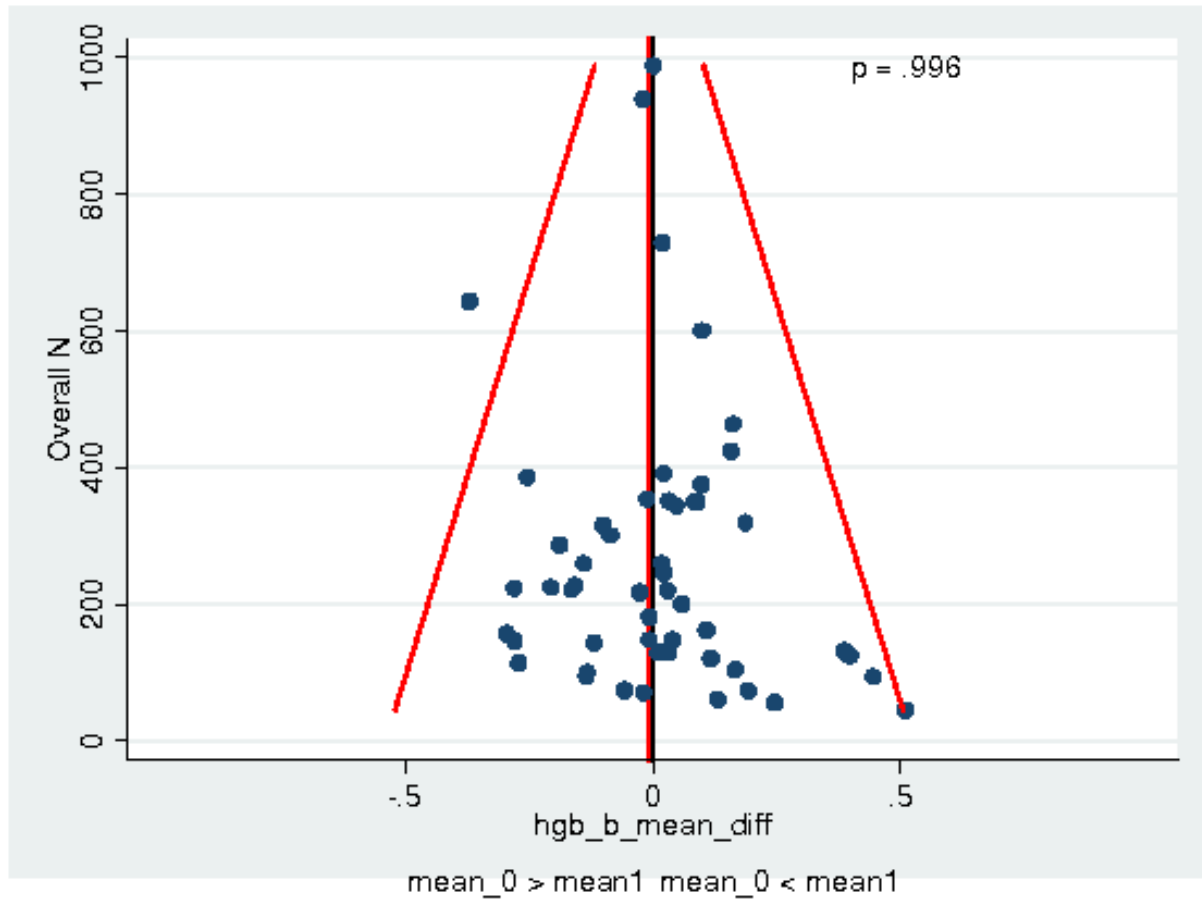
Time from cancer diagnosis to date of randomization [Figure 26](#)

Figure 26. Time from cancer diagnosis to date of randomization



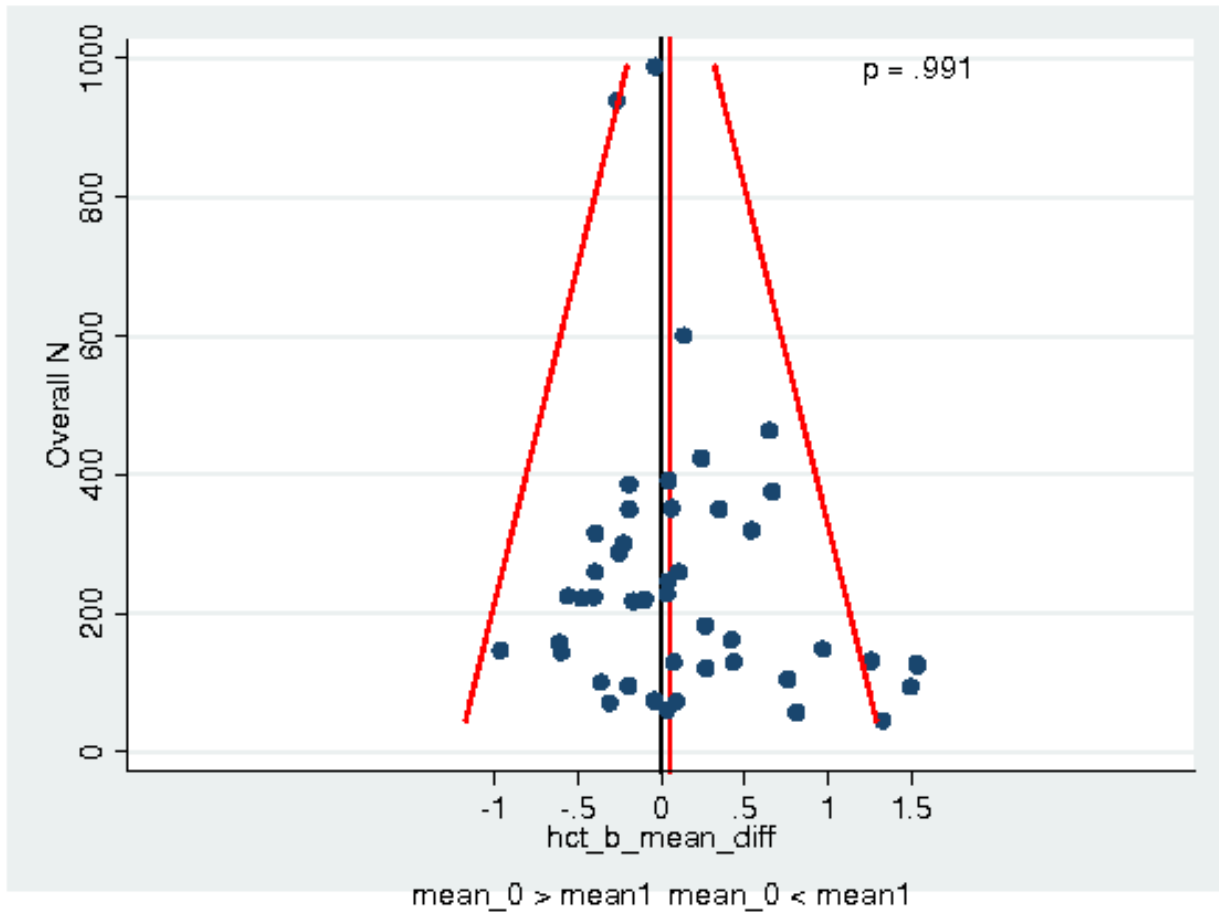
Hemoglobin [Figure 27](#)

Figure 27. Hemoglobin



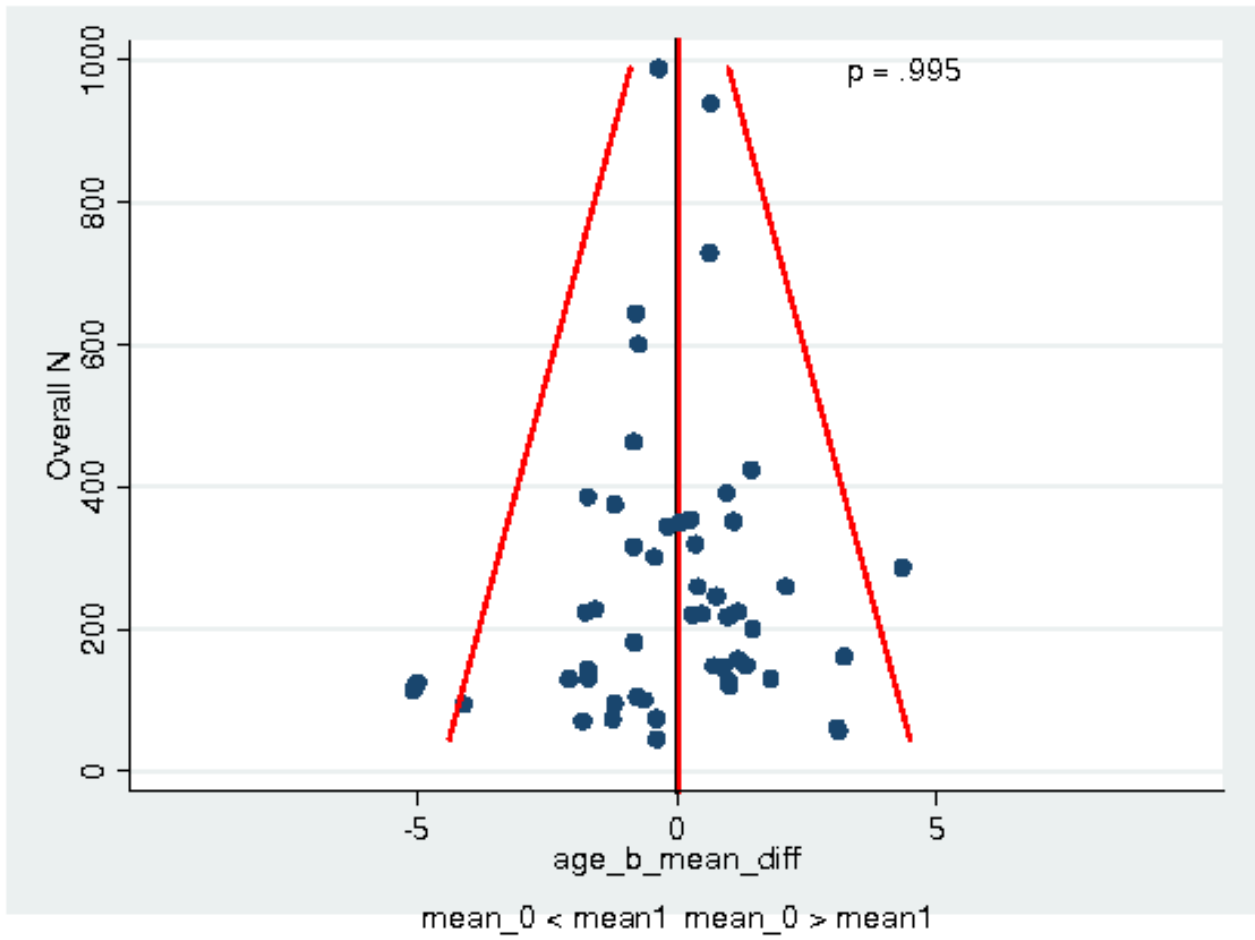
Hematocrit [Figure 28](#)

Figure 28. Hematocrit



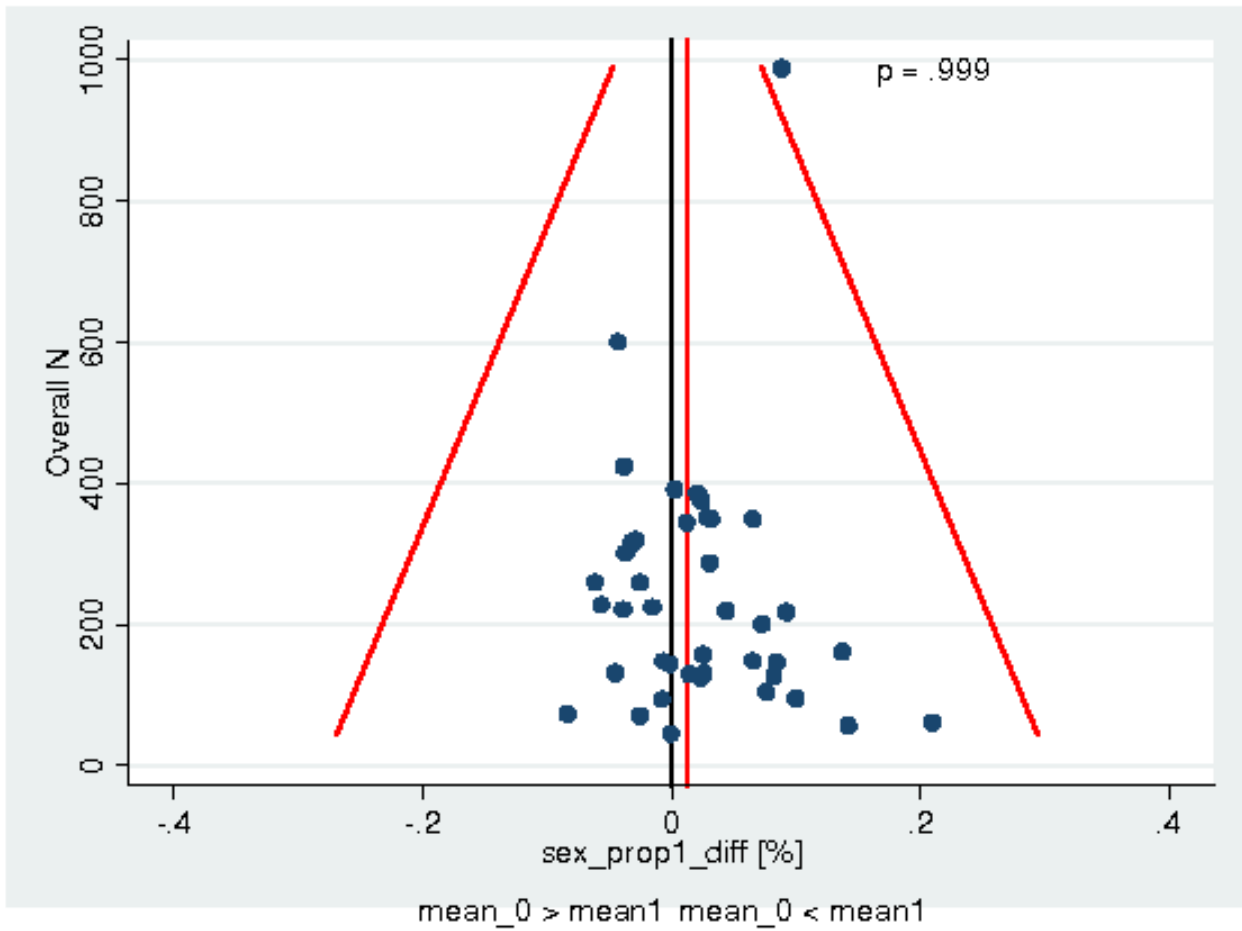
Age Figure 29

Figure 29. Age



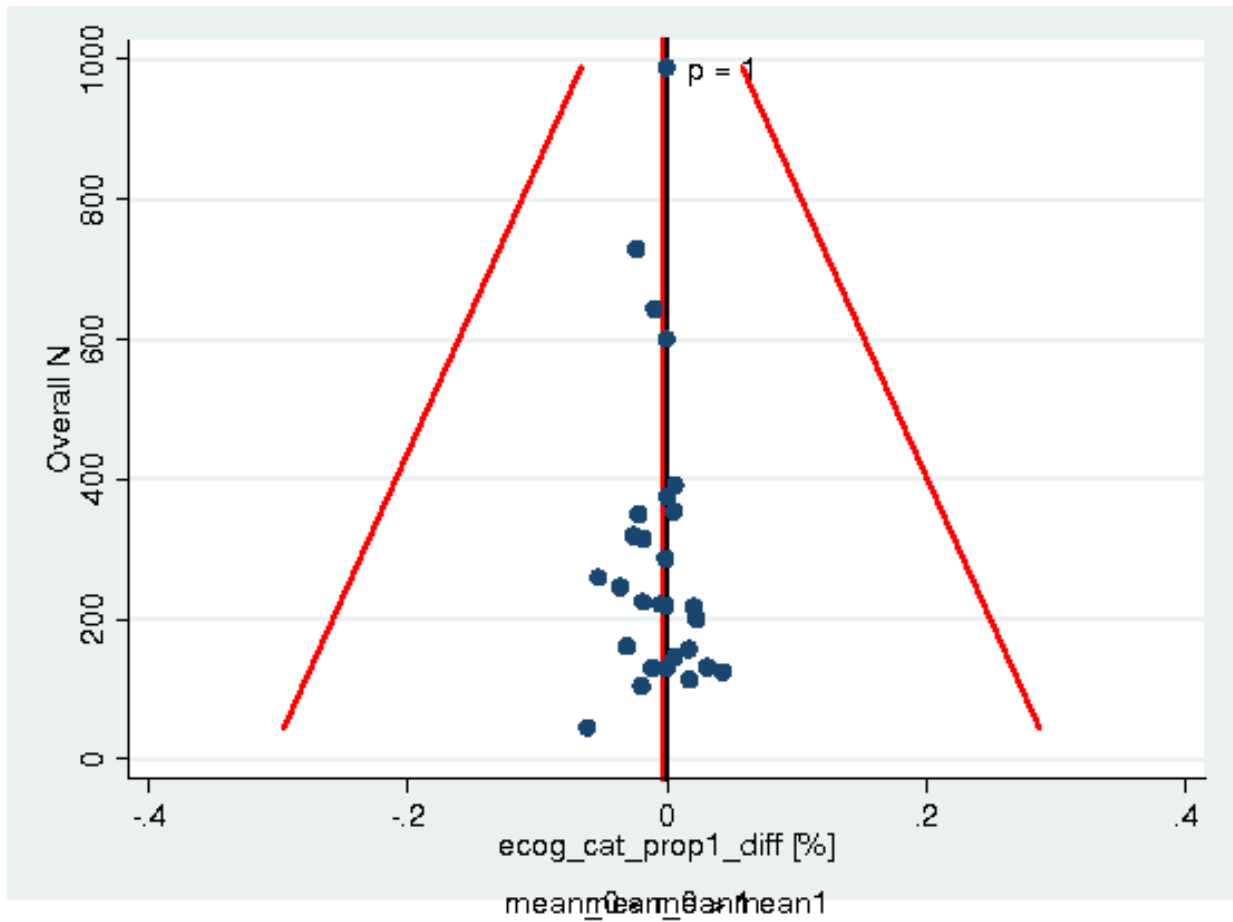
Sex Figure 30

Figure 30. Sex



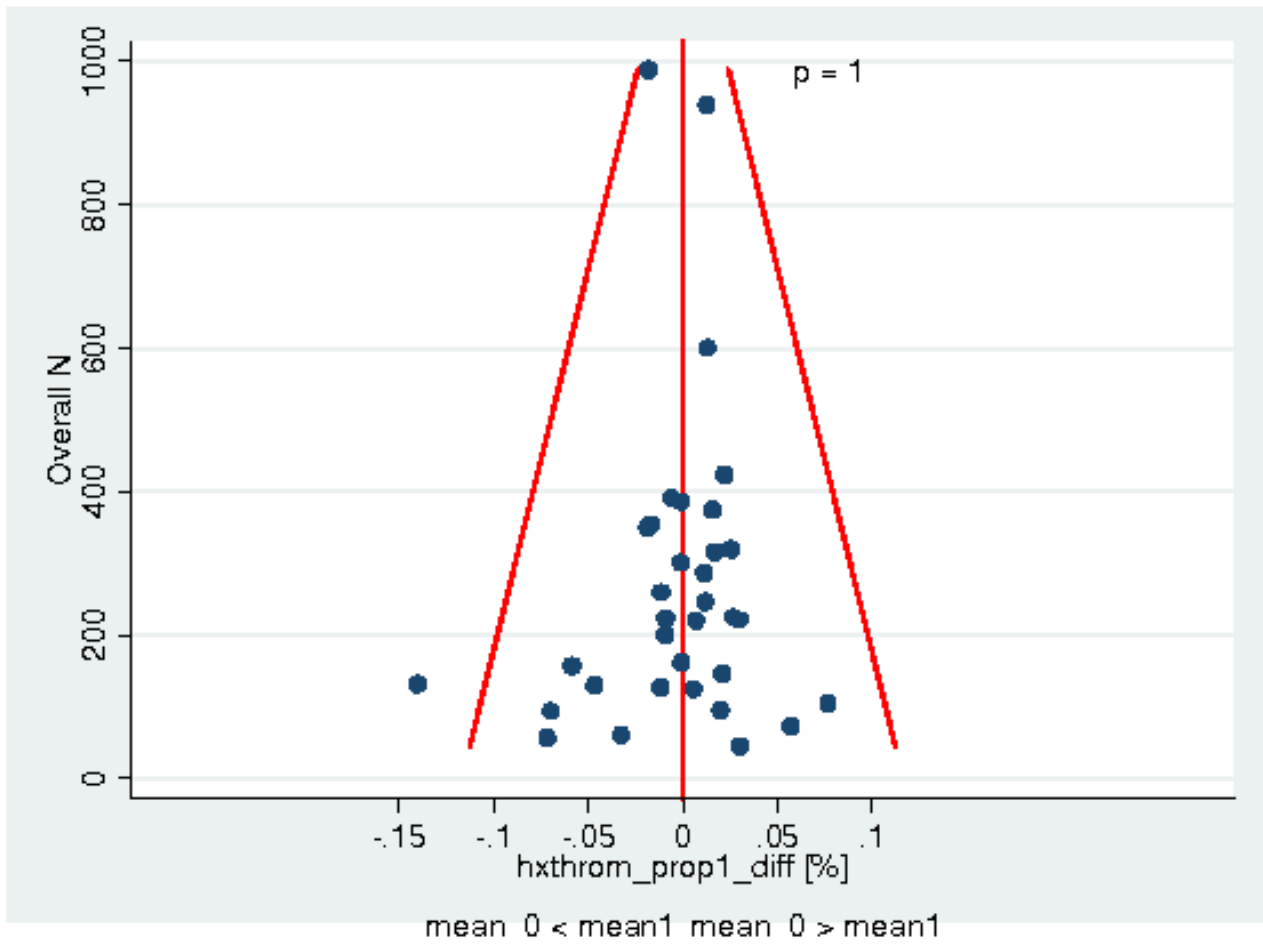
ECOG low versus high [Figure 31](#)

Figure 31. ECOG low versus high



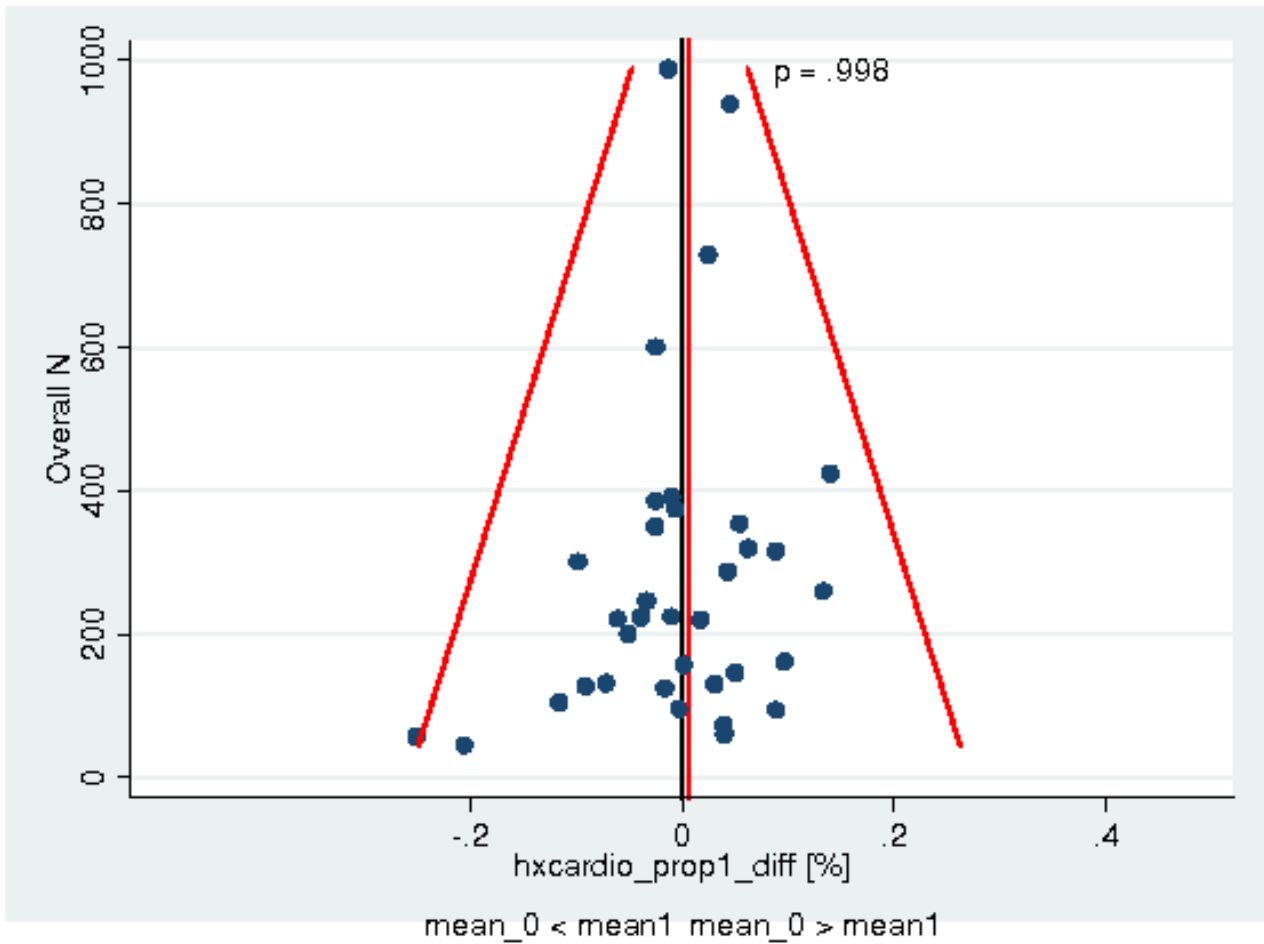
History of thromboembolic events [Figure 32](#)

Figure 32. History of thromboembolic events



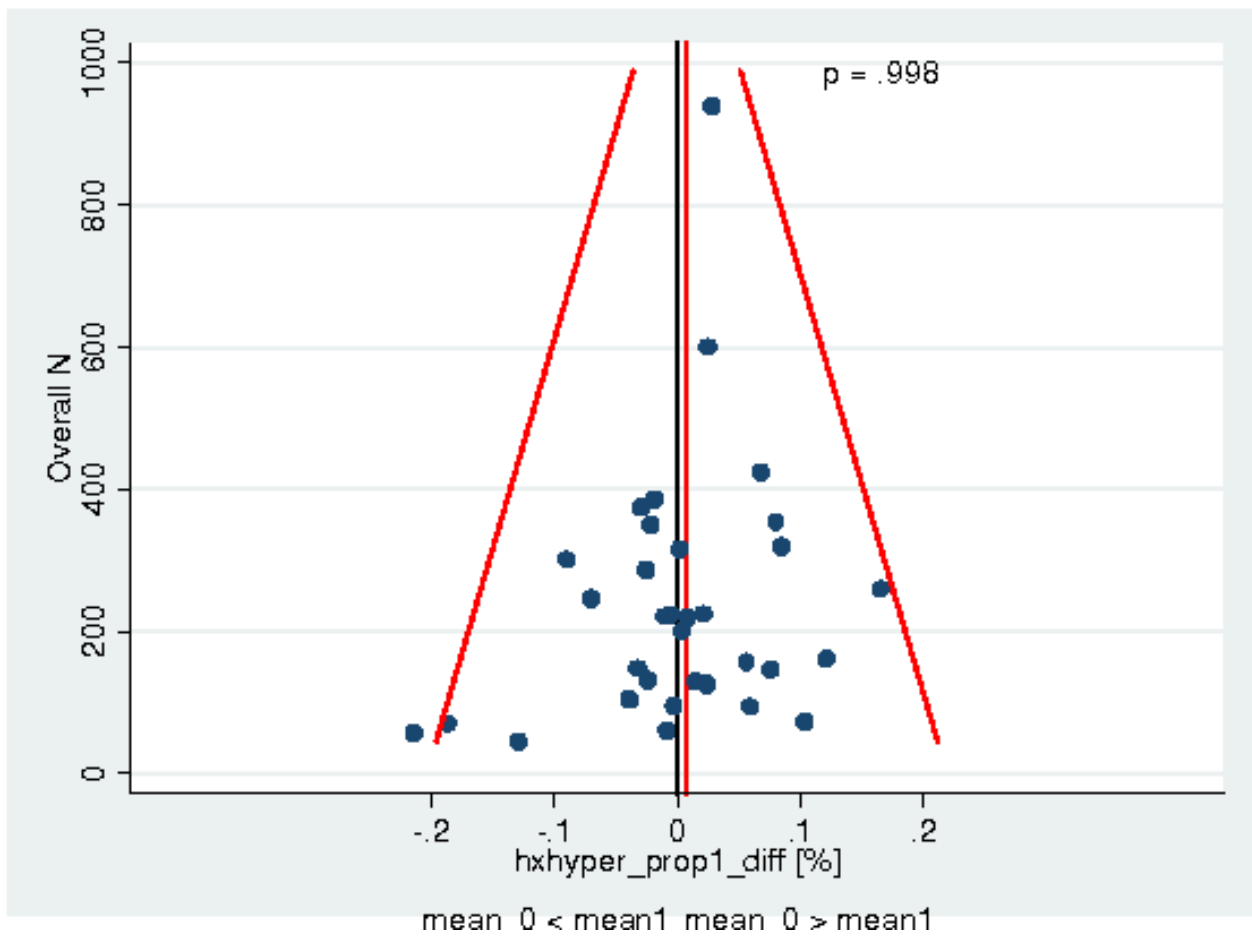
History of cardiovascular events [Figure 33](#)

Figure 33. History of cardiovascular events



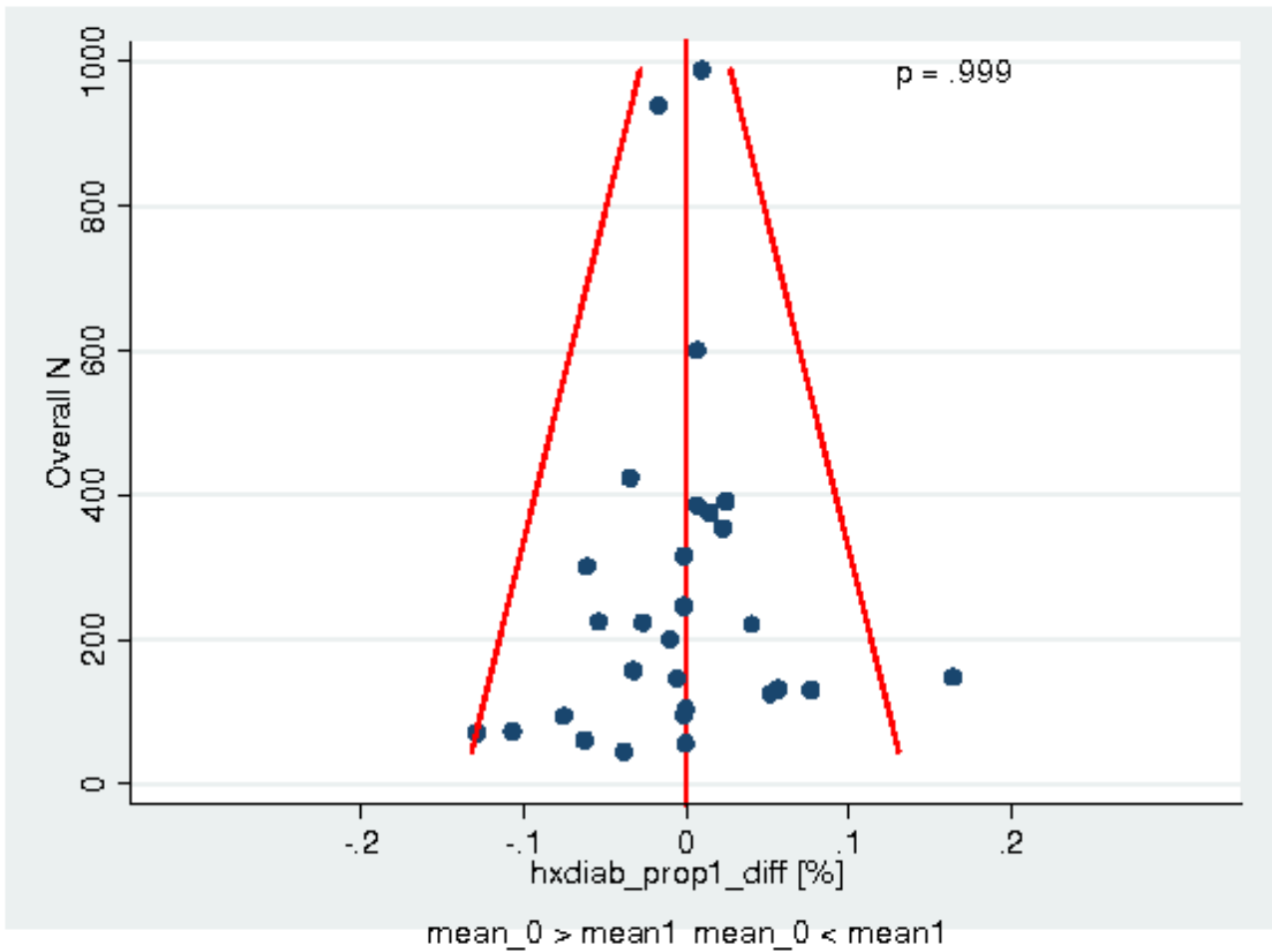
History of hypertension [Figure 34](#)

Figure 34. History of hypertension



History of diabetes [Figure 35](#)

Figure 35. History of diabetes



Appendix 6. Assessment of interaction for mortality in all cancer patients during the active study period

Mortality in all cancer patients during the active study period	ESA arm				Control arm			ESA versus control		P value*
	Patients	events	sample	%	events	sample	%	HR	95% CI	
Patient level characteristics										
Hb at baseline (continuous)										0.82
Hb at baseline (cat. 1)										0.75
Hb ≤ 8 g/dL	791	90	448	20%	58	343	17%	1.28	0.92-1.78	
Hb 8-≤ 10 g/dL	3930	292	2222	13%	239	1708	14%	1.08	0.91-1.28	
Hb 10-≤ 12 g/dL	5004	300	2851	11%	220	2153	10%	1.22	1.03-1.46	
Hb 12-≤ 14 g/dL	2843	141	1433	10%	114	1410	8%	1.28	1.00-1.64	
Hb > 14 g/dL	839	37	428	9%	30	411	7%	1.06	0.66-1.72	
Unknown	526	5	252	2%	4	274	1%	0.91	0.24-3.40	
Hb at baseline (cat. 2)										0.79
Hb ≤ 8 g/dL	791	90	448	20%	58	343	17%	1.28	0.92-1.79	
Hb 8-≤ 9 g/dL	1319	117	742	16%	101	577	18%	1.05	0.81-1.38	
Hb 9-≤ 10 g/dL	2611	175	1480	12%	138	1131	12%	1.11	0.89-1.39	
Hb 10-≤ 11 g/dL	2927	188	1699	11%	121	1228	10%	1.34	1.07-1.69	
Hb 11-≤ 12 g/dL	2077	112	1152	10%	99	925	11%	1.07	0.82-1.41	
Hb 12-≤ 13 g/dL	1739	92	873	11%	80	866	9%	1.22	0.90-1.64	
Hb 13-≤ 14 g/dL	1104	49	560	9%	34	544	6%	1.45	0.93-2.24	
Hb >14 g/dL	839	37	428	9%	30	411	7%	1.06	0.65-1.72	

<i>(Continued)</i>										
Unknown	526	5	252	2%	4	274	1%	0.92	0.25-3.44	
Malignancy type										
Tumour (cat. 1)										0.16
Haematological malignancies	2403	128	1400	9%	79	1003	8%	1.20	0.91-1.60	
Solid tumours	10795	684	5848	12%	532	4947	11%	1.20	1.07-1.35	
Other	693	49	369	13%	51	324	16%	0.81	0.54-1.20	
Missing / unknown	42	4	17	24%	3	25	12%	1.99	0.44-8.94	
Tumour (cat. 2)										0.47
Haematological malignancies	2403	128	1400	9%	79	1003	8%	1.19	0.90-1.59	
Breast cancer	4302	224	2245	10%	164	2057	8%	1.34	1.10-1.65	
Head and neck cancer	868	23	443	5%	20	425	5%	1.13	0.62-2.07	
Lung cancer	3076	292	1618	18%	243	1458	17%	1.17	0.99-1.39	
Gastrointestinal cancer	708	61	434	14%	44	274	16%	0.96	0.65-1.42	
Gynaecological cancer	1399	40	842	5%	27	557	5%	1.18	0.72-1.94	
Genitourinary cancer	442	44	266	17%	34	176	19%	1.02	0.65-1.60	
Other	693	49	369	13%	51	324	16%	0.81	0.54-1.20	
Missing / unknown	42	4	17	24%	3	25	12%	1.96	0.44-8.79	
Sex										
Male	5136	419	2854	15%	309	2282	14%	1.15	0.99-1.34	0.86
Female	8797	446	4780	9%	356	4017	9%	1.17	1.02-1.35	
Age										

(Continued)

Age continuous										0.87
Age categorical										0.50
< 18 years	123	0	55	0%	1	68	1%	Not estimable	Not estimable	
≥18-35 years	346	11	191	6%	9	155	6%	0.83	0.34-2.01	
≥35-45 years	1343	57	745	8%	34	598	6%	1.36	0.89-2.08	
≥45-55 years	3010	162	1614	10%	111	1396	8%	1.34	1.05-1.71	
≥55-65 years	4193	256	2237	11%	222	1956	11%	1.07	0.89-1.28	
≥65-75 years	3517	271	1970	14%	210	1547	14%	1.16	0.97-1.39	
≥75 years	1389	108	816	13%	77	573	13%	1.27	0.94-1.70	
Missing	12	0	6	0%	1	6	17%	Not estimable	Not estimable	
Hct levels at baseline										
Hct continuous										0.57
Hct categorical										0.01
≤23.5%	390	55	210	26%	24	180	13%	2.19	1.35-3.55	
23.5-≤29.4%	2788	199	1567	13%	191	1221	16%	0.96	0.78-1.17	
29.4-≤35.3%	4615	321	2692	12%	223	1923	12%	1.17	0.99-1.39	
35.3-≤41.2%	2458	176	1258	14%	130	1200	11%	1.41	1.12-1.76	
> 41.2%	785	48	414	12%	40	371	11%	1.12	0.73-1.70	
Missing	2897	66	1493	4%	57	1404	4%	1.09	0.76-1.55	
Serum Epo at baseline										

(Continued)

Serum Epo continuous										0.21
Serum Epo categorical										0.54
<25 mU/ml	1497	95	876	11%	58	621	9%	1.33	0.96-1.85	
25-<100 mU/ml	2908	195	1643	12%	171	1265	14%	0.98	0.80-1.21	
100-<200 mU/ml	740	73	451	16%	47	289	16%	1.08	0.75-1.57	
200-<500 mU/ml	325	29	190	15%	19	135	14%	1.29	0.72-2.31	
> 500 mU/ml	181	21	103	20%	10	78	13%	1.26	0.59-2.69	
Unknown	8282	452	4371	10%	360	3911	9%	1.23	1.07-1.41	
Performance score										
ECOG categorical										0.63
ECOG 0	3392	86	1808	5%	76	1584	5%	1.15	0.85-1.57	
ECOG 1	4900	327	2779	12%	250	2121	12%	1.14	0.97-1.35	
ECOG 2	1678	241	933	26%	178	745	24%	1.21	1.00-1.47	
ECOG 3	139	26	77	34%	18	62	29%	1.30	0.71-2.39	
ECOG 4	3	1	2	50%	0	1	0%	Not es- timable	Not estimable	
ECOG missing	3821	184	2035	9%	143	1786	8%	1.12	0.90-1.39	
ECOG dichotomous										0.56
ECOG 0, 1, 2	10083	655	5578	12%	505	4505	11%	1.18	1.05-1.33	
ECOG 3, 4	142	27	79	34%	18	63	29%	1.42	0.78-2.59	
ECOG missing	3708	183	1977	9%	142	1731	8%	1.12	0.89-1.39	
Body mass index										

(Continued)

≤ 19 kg/m ²	865	76	424	18%	73	441	17%	1.00	0.73-1.39	0.72
19- ≤25 kg/m ²	5487	374	2964	13%	277	2523	11%	1.21	1.04-1.42	
25-≤ 30 kg/m ²	3443	193	1864	10%	144	1579	9%	1.14	0.92-1.42	
> 30 kg/m ²	1650	74	867	9%	56	783	7%	1.26	0.89-1.79	
Missing	2488	148	1515	10%	115	973	12%	1.22	0.95-1.57	
History of thromboembolic events										
Yes	561	40	318	13%	42	243	17%	0.80	0.52-1.23	0.06
No	9059	637	5044	13%	474	4015	12%	1.23	1.09-1.39	
Missing / not reported	4313	188	2272	8%	149	2041	7%	1.09	0.87-1.35	
History of cardiovascular events										
Yes	3593	273	2002	14%	197	1591	12%	1.24	1.03-1.49	0.62
No	6729	404	3700	11%	319	3029	11%	1.17	1.01-1.35	
Missing / not reported	3611	188	1932	10%	149	1679	9%	1.09	0.87-1.35	
History of hypertension										
Yes	2093	140	1219	11%	107	874	12%	1.15	0.90-1.49	0.76
No	7527	537	4143	13%	409	3384	12%	1.21	1.06-1.37	
Missing / not reported	4313	188	2272	8%	149	2041	7%	1.09	0.88-1.35	
History of diabetes mellitus										
Yes	709	62	372	17%	56	337	17%	1.12	0.78-1.61	0.70
No	7316	555	3927	14%	427	3389	13%	1.21	1.06-1.37	
Missing / not reported	5908	248	3335	7%	182	2573	7%	1.11	0.91-1.34	

(Continued)

Geographical region										
Northern America	3569	184	2004	9%	159	1565	10%	1.08	0.87-1.34	0.17
Northern, Western & Southern Europe	7440	403	4030	10%	320	3410	9%	1.08	0.93-1.26	
Eastern Europe	1955	234	1030	23%	151	925	16%	1.44	1.17-1.77	
Australia & New Zealand	342	20	216	9%	11	126	9%	1.42	0.68-2.97	
Other	226	13	123	11%	13	103	13%	0.90	0.42-1.93	
Missing / not reported	401	11	231	5%	11	170	6%	0.98	0.42-2.26	
Tumour stage										
Metastatic / advanced	8113	692	4482	15%	527	3631	15%	1.20	1.07-1.34	0.76
Not metastatic / not advanced	4039	63	2116	3%	45	1923	2%	1.28	0.87-1.87	
Missing / not reported	1781	110	1036	11%	93	745	12%	0.92	0.69-1.22	
Planned Hb ceiling										
Planned Hb ceiling (cat. 1)										0.98
≤Hb 13.0 g/dL	3043	209	1624	13%	157	1419	11%	1.19	0.97-1.47	
Hb 13.0 - ≤15.0 g/dL	10193	599	5631	11%	468	4562	10%	1.16	1.03-1.32	
Hb >15.0 g/dL	494	29	259	11%	23	235	10%	1.22	0.70-2.11	
Other	203	28	120	23%	17	83	20%	1.12	0.61-2.06	
Planned Hb ceiling (cat. 2)										0.88
≤Hb 13.0 g/dL	3043	209	1624	13%	157	1419	11%	1.19	0.97-1.47	
Hb 13.0 - ≤14.0 g/dL	6816	381	3733	10%	322	3083	10%	1.12	0.97-1.31	
Hb 14.0 - ≤15.0 g/dL	3377	218	1898	11%	146	1479	10%	1.25	1.01-1.54	

(Continued)

>Hb 15.0 g/dL	494	29	259	11%	23	235	10%	1.22	0.70-2.11	
Other	203	28	120	23%	17	83	20%	1.12	0.61-2.06	
Study level characteristics										
Treatment population										
Treatment population (cat. 1)										
Chemotherapy	10441	605	5676	11%	490	4765	10%	1.10	0.98-1.24	0.42
Radiochemotherapy	737	31	368	8%	20	369	5%	1.50	0.85-2.63	
Radiotherapy	799	19	408	5%	12	391	3%	1.52	0.74-3.14	
Mixed	266	17	175	10%	7	91	8%	1.53	0.63-3.69	
None	1690	193	1007	19%	136	683	20%	1.33	1.06-1.66	
Treatment population (cat. 2)										
Chemotherapy	10441	605	5676	11%	490	4765	10%	1.10	0.98-1.24	0.27
Radiotherapy / radiochemotherapy	1536	50	776	6%	32	760	4%	1.51	0.97-2.35	
Mixed	266	17	175	10%	7	91	8%	1.53	0.63-3.69	
None	1690	193	1007	19%	136	683	20%	1.33	1.06-1.66	
Iron supplementation										
Fixed iron supplementation	2589	71	1293	5%	60	1296	5%	1.17	0.83-1.65	0.48
Iron supplementation as needed	11120	778	6232	12%	584	4888	12%	1.18	1.06-1.32	
Other	224	16	109	15%	21	115	18%	0.79	0.41-1.51	
Planned ESA treatment duration										
Up to 8 weeks	415	21	256	8%	17	159	11%	0.96	0.50-1.84	0.33

(Continued)

9-16 weeks	4800	244	2738	9%	204	2062	10%	1.08	0.89-1.30	
> 17 weeks	3269	388	1701	23%	286	1568	18%	1.30	1.12-1.52	
Until end of chemo- or radiotherapy	5449	212	2939	7%	158	2510	6%	1.09	0.88-1.34	
Planned weekly ESA dosage										
< 100 µg Darbepoetin or < 40000 IU Epoetin	4197	238	2297	10%	193	1900	10%	0.98	0.81-1.19	0.12
= 100 µg Darbepoetin or = 40000 IU Epoetin	3081	240	1545	16%	190	1536	12%	1.36	1.12-1.64	
> 100 µg Darbepoetin or > 40000 IU Epoetin	3845	250	2076	12%	184	1769	10%	1.23	1.01-1.49	
Other	2810	137	1716	8%	98	1094	9%	1.11	0.85-1.45	
Planned frequency of ESA application										
Three times per week or more frequent	6131	311	3458	9%	238	2673	9%	1.01	0.85-1.20	0.03
Once per week	3948	303	1972	15%	231	1976	12%	1.40	1.18-1.66	
Every second week or less frequent	3036	180	1795	10%	122	1241	10%	1.25	0.99-1.57	
Other	818	71	409	17%	74	409	18%	0.93	0.67-1.29	
Placebo controlled trial										
Yes	7657	594	4211	14%	456	3446	13%	1.21	1.07-1.37	0.38
No	6276	271	3423	8%	209	2853	7%	1.09	0.91-1.31	
Randomisation										
Adequate	3882	303	2047	15%	245	1835	13%	1.17	0.99-1.39	0.98
Unclear	10051	562	5587	10%	420	4464	9%	1.17	1.03-1.33	
Concealment of allocation										
Adequate	10595	744	5839	13%	559	4756	12%	1.20	1.08-1.34	0.23

(Continued)

Unclear	3338	121	1795	7%	106	1543	7%	1.01	0.78-1.31	
Endpoint survival										
Primary endpoint	3116	247	1547	16%	195	1569	12%	1.30	1.08-1.57	0.41
Secondary endpoint	4313	213	2282	9%	161	2031	8%	1.10	0.89-1.35	
Safety /adverse events	6504	405	3805	11%	309	2699	11%	1.13	0.97-1.32	
Year of last patient randomized										
1990-1994	1447	95	890	11%	67	557	12%	0.95	0.69-1.30	0.24
1995-1999	1725	95	1001	9%	70	724	10%	0.96	0.70-1.32	
2000-2004	7620	431	4105	10%	337	3515	10%	1.26	1.10-1.46	
2005-2006	3141	244	1638	15%	191	1503	13%	1.18	0.98-1.43	
Source of data										
Manufacturer	12229	846	6789	12%	641	5440	12%	1.19	1.07-1.32	0.13
Clinical study group	1704	19	845	2%	24	859	3%	0.74	0.41-1.35	
*P value for likelihood-ratio test, patients with missing data are excluded from the test, analysis based on one-stage Cox fixed-effects model stratified by study										
ESA=erythropoiesis-stimulating agents										

Appendix 7. Assessment of interaction for mortality in chemotherapy trials during the active study period

Mortality in chemotherapy trials during the active study period											
Subgroups	ESA arm				Control arm				ESA versus control		p value*
	Patients	events	sample	%	events	sample	%	HR	95% CI		
Patient level characteristics											
Hb at baseline (continuous)										0.87	
Hb at baseline (cat 1)										0.90	
Hb ≤ 8 g/dL	569	52	321	16%	34	248	14%	1.20	0.78-1.86		
Hb 8-≤ 10 g/dL	2888	188	1606	12%	156	1282	12%	1.07	0.86-1.33		
Hb 10-≤ 12 g/dL	3748	213	2121	10%	171	1627	11%	1.10	0.90-1.34		
Hb 12-≤ 14 g/dL	2185	119	1108	11%	100	1077	9%	1.23	0.94-1.60		
Hb >14 g/dL	555	29	286	10%	25	269	9%	0.96	0.56-1.65		
Unknown	496	4	234	2%	4	262	2%	0.76	0.19-3.05		
Hb at baseline (cat 2)										0.99	
Hb ≤ 8 g/dL	569	52	321	16%	34	248	14%	1.21	0.78-1.86		
Hb 8-≤ 9 g/dL	949	72	549	13%	59	400	15%	1.01	0.72-1.44		
Hb 9-≤ 10 g/dL	1939	116	1057	11%	97	882	11%	1.10	0.84-1.44		
Hb 10-≤ 11 g/dL	2074	113	1179	10%	86	895	10%	1.11	0.84-1.47		
Hb 11-≤ 12 g/dL	1674	100	942	11%	85	732	12%	1.08	0.81-1.45		
Hb 12-≤ 13 g/dL	1359	80	679	12%	68	680	10%	1.26	0.91-1.74		
Hb 13-≤ 14 g/dL	826	39	429	9%	32	397	8%	1.19	0.74-1.89		

(Continued)

Hb >14 g/dL	555	29	286	10%	25	269	9%	0.96	0.56-1.65	
Unknown	496	4	234	2%	4	262	2%	0.77	0.19-3.07	
Malignancy type										
Tumour (cat. 1)										0.18
Haematological malignancies	1832	99	1034	10%	65	798	8%	1.12	0.81-1.54	
Solid tumours	7967	464	4311	11%	379	3656	10%	1.14	0.99-1.31	
Other	600	38	314	12%	43	286	15%	0.74	0.48-1.15	
Missing / unknown	42	4	17	24%	3	25	12%	1.96	0.44-8.81	
Tumour (cat. 2)										0.15
Haematological malignancies	1832	99	1034	10%	65	798	8%	1.11	0.81-1.53	
Breast cancer	4038	209	2076	10%	152	1962	8%	1.38	1.12-1.70	
Head and neck cancer	26	1	12	8%	2	14	14%	0.63	0.06-6.99	
Lung cancer	2237	187	1172	16%	173	1065	16%	1.03	0.83-1.26	
Gastrointestinal cancer	429	32	267	12%	26	162	16%	0.81	0.48-1.37	
Gynaecological cancer	1077	28	681	4%	18	396	5%	1.06	0.59-1.95	
Genitourinary cancer	160	7	103	7%	8	57	14%	0.61	0.22-1.72	
Other	600	38	314	12%	43	286	15%	0.74	0.48-1.15	
Missing / unknown	42	4	17	24%	3	25	12%	1.92	0.43-8.62	
Sex										
Male	3125	241	1720	14%	209	1405	15%	0.99	0.82-1.19	0.14
Female	7316	364	3956	9%	281	3360	8%	1.18	1.01-1.39	

(Continued)

Age									
Age continuous	0.57								
Age categorical	0.34								
< 18 years	123	0	55	0%	1	68	1%	Not estimable	Not estimable
≥18-35 years	312	9	171	5%	8	141	6%	0.78	0.30-2.03
≥35-45 years	1135	45	620	7%	28	515	5%	1.34	0.83-2.14
≥45-55 years	2425	123	1311	9%	93	1114	8%	1.22	0.93-1.60
≥55-65 years	3233	175	1724	10%	172	1509	11%	0.93	0.75-1.15
≥65-75 years	2444	190	1359	14%	146	1085	13%	1.16	0.93-1.44
≥75 years	758	63	430	15%	41	328	13%	1.28	0.86-1.90
Missing / unknown	11	0	6	0%	1	5	20%	Not estimable	Not estimable
Hct levels at baseline									
Hct continuous	0.57								
Hct categorical	0.22								
≤ 23.5%	275	29	144	20%	17	131	13%	1.61	0.88-2.94
23.5-≤ 29.4%	2033	118	1135	10%	109	898	12%	0.96	0.74-1.25
29.4-≤ 35.3%	3281	208	1882	11%	163	1399	12%	1.02	0.83-1.25
35.3-≤ 41.2%	1801	152	931	16%	115	870	13%	1.36	1.07-1.73
> 41.2%	459	39	249	16%	33	210	16%	1.07	0.67-1.71
Missing / unknown	2592	59	1335	4%	53	1257	4%	1.04	0.72-1.52

(Continued)

Serum Epo at baseline									
Serum Epo continuous									0.91
Serum Epo categorical									0.20
< 25 mU/ml	1032	68	608	11%	41	424	10%	1.34	0.91-1.98
25-<100 mU/ml	2083	110	1162	9%	114	921	12%	0.79	0.61-1.03
100-<200 mU/ml	518	45	314	14%	28	204	14%	1.14	0.71-1.84
200-<500 mU/ml	227	18	134	13%	11	93	12%	1.18	0.56-2.51
≥ 500 mU/ml	99	8	57	14%	4	42	10%	1.01	0.30-3.39
Missing / unknown	6482	356	3401	10%	292	3081	9%	1.18	1.01-1.38
Performance score									
ECOG categorical									0.58
ECOG 0	3025	77	1582	5%	66	1443	5%	1.23	0.89-1.71
ECOG 1	3784	237	2105	11%	185	1679	11%	1.10	0.91-1.34
ECOG 2	1140	137	623	22%	114	517	22%	1.07	0.84-1.38
ECOG 3	105	15	57	26%	13	48	27%	0.98	0.46-2.07
ECOG 4	3	1	2	50%	0	1	0%	Not estimable	Not estimable
ECOG missing / unknown	2384	138	1307	11%	112	1077	10%	1.04	0.80-1.33
ECOG dichotomous									1.00
ECOG 0, 1, 2	7949	451	4310	10%	365	3639	10%	1.12	0.98-1.29
ECOG 3, 4	108	16	59	27%	13	49	27%	1.12	0.54-2.34
ECOG missing	2384	138	1307	11%	112	1077	10%	1.03	0.80-1.33

(Continued)

Body mass index										
≤ 19 kg/m ²	607	43	292	15%	45	315	14%	0.95	0.63-1.45	0.63
19-≤ 25 kg/m ²	4283	262	2318	11%	208	1965	11%	1.11	0.93-1.34	
25-≤ 30 kg/m ²	2698	143	1468	10%	116	1230	9%	1.01	0.79-1.30	
> 30 kg/m ²	1294	60	686	9%	44	608	7%	1.32	0.89-1.94	
Missing / not reported	1559	97	912	11%	77	647	12%	1.22	0.90-1.65	
History of thromboembolic events										
Yes	375	27	207	13%	29	168	17%	0.76	0.45-1.28	0.14
No	6292	400	3469	12%	320	2823	11%	1.14	0.98-1.32	
Missing / not reported	3774	178	2000	9%	141	1774	8%	1.08	0.86-1.35	
History of cardiovascular events										
Yes	2319	161	1295	12%	126	1024	12%	1.11	0.88-1.41	0.93
No	5050	266	2721	10%	223	2329	10%	1.10	0.92-1.31	
Missing / not reported	3072	178	1660	11%	141	1412	10%	1.08	0.86-1.35	
History of hypertension										
Yes	1396	111	798	14%	81	598	14%	1.18	0.89-1.57	0.61
No	5271	316	2878	11%	268	2393	11%	1.08	0.92-1.28	
Missing / not reported	3774	178	2000	9%	141	1774	8%	1.08	0.86-1.35	
History of diabetes mellitus										

(Continued)

Yes	430	36	219	16%	37	211	18%	1.01	0.64-1.61	0.74
No	5149	350	2786	13%	286	2363	12%	1.10	0.94-1.29	
Missing / not reported	4862	219	2671	8%	167	2191	8%	1.12	0.91-1.37	
Geographical region										
Northern America	2083	92	1088	8%	95	995	10%	0.95	0.71-1.26	0.35
Northern, Western & Southern Europe	6082	341	3342	10%	267	2740	10%	1.05	0.90-1.24	
Eastern Europe	1413	135	734	18%	98	679	14%	1.34	1.03-1.73	
Australia & New Zealand	286	14	184	8%	7	102	7%	1.59	0.64-3.95	
Other	189	13	106	12%	13	83	16%	0.90	0.42-1.94	
Missing / not reported	388	10	222	5%	10	166	6%	1.02	0.42-2.45	
Tumour stage										
Metastatic / advanced	6054	491	3325	15%	388	2729	14%	1.16	1.01-1.32	0.61
Not metastatic / not advanced	2902	25	1491	2%	24	1411	2%	1.00	0.57-1.75	
Missing / not reported	1485	89	860	10%	78	625	12%	0.82	0.60-1.12	
Planned Hb ceiling										
Planned Hb ceiling (cat 1)										0.28
≤Hb 13.0 g/dL	1631	47	841	6%	49	790	6%	0.83	0.56-1.25	
Hb 13.0 - ≤15.0 g/dL	8451	523	4630	11%	415	3821	11%	1.14	1.00-1.30	
Hb >15.0 g/dL	280	20	150	13%	21	130	16%	0.90	0.48-1.67	
Other	79	15	55	27%	5	24	21%	1.43	0.52-3.93	
Planned Hb ceiling (cat 2)										0.38

(Continued)

≤Hb 13.0 g/dL	1631	47	841	6%	49	790	6%	0.83	0.56-1.25	
Hb 13.0 – ≤14.0 g/dL	5930	323	3200	10%	277	2730	10%	1.10	0.93-1.29	
Hb 14.0 – ≤15.0 g/dL	2521	200	1430	14%	138	1091	13%	1.22	0.98-1.52	
>Hb 15.0 g/dL	280	20	150	13%	21	130	16%	0.90	0.48-1.67	
Other	79	15	55	27%	5	24	21%	1.43	0.52-3.93	
Study level characteristics										
Iron supplementation										
Fixed iron supplementation	1904	40	947	4%	40	957	4%	1.00	0.64-1.55	0.52
Iron supplementation as needed	8313	549	4620	12%	429	3693	12%	1.12	0.99-1.28	
Other	224	16	109	15%	21	115	18%	0.79	0.41-1.51	
Planned ESA treatment duration										
up to 8 weeks	143	3	114	3%	2	29	7%	0.38	0.06-2.30	0.20
9-16 weeks	3823	183	2075	9%	167	1748	10%	1.01	0.82-1.25	
> 17 weeks	2280	252	1184	21%	192	1096	18%	1.27	1.05-1.53	
Until end of chemo- or radiotherapy	4195	167	2303	7%	129	1892	7%	1.00	0.79-1.26	
Planned weekly ESA dosage										
< 100 µg Darbepoetin or < 40000 IU Epoetin	3733	208	2023	10%	174	1710	10%	0.96	0.78-1.18	0.29
≤ 100 µg Darbepoetin or = 40000 IU Epoetin	2200	179	1101	16%	144	1099	13%	1.29	1.04-1.61	
> 100 µg Darbepoetin or > 40000 IU Epoetin	1998	86	987	9%	76	1011	8%	1.11	0.82-1.51	
Other	2510	132	1565	8%	96	945	10%	1.08	0.83-1.42	
Planned frequency of ESA application										

(Continued)

Three times per week or more frequent	5016	267	2853	9%	210	2163	10%	0.97	0.81-1.17	0.05
Once per week	3067	242	1528	16%	185	1539	12%	1.35	1.12-1.64	
Every second week or less frequent	1540	25	886	3%	21	654	3%	0.92	0.51-1.68	
Other	818	71	409	17%	74	409	18%	0.93	0.67-1.29	
Placebo controlled trial										
Yes	5473	379	2996	13%	307	2477	12%	1.13	0.97-1.32	0.53
No	4968	226	2680	8%	183	2288	8%	1.05	0.86-1.28	
Randomisation										
Adequate	3258	244	1693	14%	202	1565	13%	1.11	0.92-1.34	0.88
Unclear	7183	361	3983	9%	288	3200	9%	1.09	0.93-1.28	
Concealment of allocation										
Adequate	8252	545	4501	12%	423	3751	11%	1.15	1.01-1.30	0.07
Unclear	2189	60	1175	5%	67	1014	7%	0.81	0.57-1.16	
Endpoint survival										
Primary endpoint	2731	221	1352	16%	177	1379	13%	1.29	1.06-1.57	0.11
Secondary endpoint	3222	189	1730	11%	147	1492	10%	1.04	0.84-1.30	
Safety /adverse events	4488	195	2594	8%	166	1894	9%	0.96	0.78-1.18	
Year of last patient randomized										
1990-1994	1057	65	650	10%	48	407	12%	0.86	0.59-1.26	0.16
1995-1999	1725	95	1001	9%	70	724	10%	0.96	0.70-1.32	

(Continued)

2000-2004	6112	374	3263	11%	298	2849	10%	1.22	1.05-1.43	
2005-2006	1547	71	762	9%	74	785	9%	0.93	0.67-1.29	
Source of data										
Manufacturer	8851	587	4889	12%	467	3962	12%	1.12	0.99-1.26	0.18
Clinical study group	1590	18	787	2%	23	803	3%	0.73	0.39-1.36	

*P value for likelihood-ratio test, patients with missing data are excluded from the test, analysis based on one-stage Cox fixed-effects model stratified by study

ESA= erythropoiesis-stimulating agents

Appendix 8. Assessment of interaction for overall survival in all cancer patients

Overall survival in all cancer patients	ESA arm				Control arm			ESA versus control		P value*
	Patients	events	sample	%	events	sample	%	HR	95% CI	
Subgroups										
Patient level characteristics										
Hb at baseline										
Hb at baseline (continuous)										0.75
Hb at baseline (cat 1)										0.63
Hb ≤ 8 g/dL	791	176	448	39%	147	343	43%	1.08	0.87-1.35	
Hb 8-≤10 g/dL	3930	725	2222	33%	672	1708	39%	1.02	0.92-1.14	
Hb 10-≤12 g/dL	5004	967	2851	34%	777	2153	36%	1.11	1.01-1.22	
Hb 12-≤14 g/dL	2843	566	1433	39%	553	1410	39%	1.06	0.95-1.20	
Hb >14 g/dL	839	155	428	36%	155	411	38%	0.94	0.75-1.18	
Unknown	526	54	252	21%	46	274	17%	1.22	0.82-1.82	
Hb at baseline (cat 2)										0.83
Hb ≤ 8 g/dL	791	176	448	39%	147	343	43%	1.08	0.87-1.35	
Hb 8-≤9 g/dL	1319	256	742	35%	252	577	44%	1.05	0.88-1.25	
Hb 9-≤10 g/dL	2611	469	1480	32%	420	1131	37%	1.02	0.89-1.16	
Hb 10-≤11 g/dL	2927	542	1699	32%	414	1228	34%	1.16	1.02-1.32	
Hb 11-≤12 g/dL	2077	425	1152	37%	363	925	39%	1.06	0.92-1.22	
Hb 12-≤13 g/dL	1739	377	873	43%	371	866	43%	1.04	0.90-1.20	
Hb 13-≤14 g/dL	1104	189	560	34%	182	544	33%	1.12	0.91-1.37	

(Continued)

Hb >14 g/dL	839	155	428	36%	155	411	38%	0.94	0.75-1.18	
Unknown	526	54	252	21%	46	274	17%	1.23	0.83-1.83	
Malignancy type										
Tumour (cat. 1)										0.23
Haematological malignancies	2403	378	1400	27%	286	1003	29%	1.19	1.02-1.39	
Solid tumours	10795	2103	5848	36%	1916	4947	39%	1.04	0.98-1.11	
Other	693	158	369	43%	145	324	45%	0.99	0.82-1.20	
Missing / unknown	42	4	17	24%	3	25	12%	2.14	0.48-9.62	
Tumour (cat. 2)										0.21
Haematological malignancies	2403	378	1400	27%	286	1003	29%	1.18	1.01-1.38	
Breast cancer	4302	563	2245	25%	481	2057	23%	1.13	1.00-1.28	
Head and neck cancer	868	235	443	53%	208	425	49%	1.14	0.91-1.42	
Lung cancer	3076	986	1618	61%	975	1458	67%	0.98	0.89-1.07	
Gastrointestinal cancer	708	124	434	29%	103	274	38%	0.89	0.68-1.16	
Gynaecological cancer	1399	115	842	14%	87	557	16%	1.13	0.85-1.50	
Genitourinal cancer	442	80	266	30%	62	176	35%	1.24	0.89-1.73	
Other	693	158	369	43%	145	324	45%	0.99	0.82-1.20	
Missing / unknown	42	4	17	24%	3	25	12%	2.12	0.47-9.50	
Sex										
Male	5136	1323	2854	46%	1193	2282	52%	1.01	0.94-1.10	0.15
Female	8797	1320	4780	28%	1157	4017	29%	1.10	1.02-1.19	

(Continued)

Age									
Age continuous									0.38
Age categorical									0.26
< 18 years	123	0	55	0%	1	68	1%	Not estimable	Not estimable
≥18-35 years	346	37	191	19%	27	155	17%	0.89	0.54-1.46
≥35-45 years	1343	196	745	26%	147	598	25%	1.02	0.82-1.26
≥45-55 years	3010	536	1614	33%	439	1396	31%	1.16	1.03-1.32
≥55-65 years	4193	818	2237	37%	793	1956	41%	1.01	0.91-1.11
≥65-75 years	3517	780	1970	40%	711	1547	46%	1.04	0.94-1.15
≥75 years	1389	276	816	34%	231	573	40%	1.20	1.00-1.43
Missing	12	0	6	0%	1	6	17%	Not estimable	Not estimable
Hct levels at baseline									
Hct continuous									0.90
Hct categorical									0.03
≤ 23.5%	390	82	210	39%	55	180	31%	1.66	1.18-2.34
23.5-≤ 29.4%	2788	476	1567	30%	479	1221	39%	0.94	0.83-1.07
29.4-≤ 35.3%	4615	945	2692	35%	732	1923	38%	1.10	0.99-1.21
35.3-≤ 41.2%	2458	579	1258	46%	558	1200	47%	1.07	0.95-1.21
> 41.2%	785	169	414	41%	165	371	44%	1.02	0.82-1.26
Missing / unknown	2897	392	1493	26%	361	1404	26%	1.08	0.93-1.24

(Continued)

Serum Epo at baseline										
Serum Epo continuous										0.14
Serum Epo categorical										0.81
< 25 mU/ml	1497	341	876	39%	309	621	50%	0.97	0.84-1.14	
25-100 mU/ml	2908	586	1643	36%	548	1265	43%	1.02	0.90-1.14	
100-200 mU/ml	740	187	451	41%	130	289	45%	1.10	0.88-1.38	
200-500 mU/ml	325	60	190	32%	51	135	38%	1.18	0.81-1.72	
> 500 mU/ml	181	31	103	30%	22	78	28%	1.08	0.63-1.88	
Unknown	8282	1438	4371	33%	1290	3911	33%	1.09	1.01-1.17	
Performance score										
ECOG categorical										0.41
ECOG 0	3392	351	1808	19%	341	1584	22%	1.06	0.91-1.23	
ECOG 1	4900	984	2779	35%	814	2121	38%	1.09	0.99-1.20	
ECOG 2	1678	490	933	53%	433	745	58%	1.01	0.89-1.15	
ECOG 3	139	48	77	62%	35	62	56%	1.18	0.76-1.82	
ECOG 4	3	2	2	100%	0	1	0%	Not estimable	Not estimable	
ECOG missing	3821	768	2035	38%	727	1786	41%	1.02	0.93-1.14	
ECOG dichotomous										0.50
ECOG 0, 1, 2	10083	1847	5578	33%	1604	4505	36%	1.08	1.01-1.15	
ECOG 3, 4	142	50	79	63%	35	63	56%	1.25	0.81-1.93	

(Continued)

ECOG missing	3708	746	1977	38%	711	1731	41%	1.02	0.92-1.13	
Body mass index										
≤ 19 kg/m ²	865	187	424	44%	195	441	44%	0.95	0.78-1.17	0.72
19-≤ 25 kg/m ²	5487	1098	2964	37%	945	2523	37%	1.06	0.97-1.15	
25-≤ 30 kg/m ²	3443	642	1864	34%	543	1579	34%	1.09	0.97-1.22	
> 30 kg/m ²	1650	250	867	29%	224	783	29%	1.03	0.86-1.24	
Missing	2488	466	1515	31%	443	973	46%	1.10	0.97-1.26	
History of thromboembolic events										
Yes	561	128	318	40%	107	243	44%	1.03	0.80-1.33	0.90
No	9059	1720	5044	34%	1509	4015	38%	1.05	0.98-1.12	
Missing / not reported	4313	795	2272	35%	734	2041	36%	1.08	0.98-1.20	
History of cardiovascular events										
Yes	3593	758	2002	38%	648	1591	41%	1.07	0.96-1.19	0.69
No	6729	1141	3700	31%	1010	3029	33%	1.04	0.96-1.13	
Missing / not reported	3611	744	1932	39%	692	1679	41%	1.07	0.97-1.19	
History of hypertension										
Yes	2093	420	1219	34%	373	874	43%	1.01	0.88-1.16	0.57
No	7527	1428	4143	34%	1243	3384	37%	1.06	0.98-1.14	
Missing / not reported	4313	795	2272	35%	734	2041	36%	1.08	0.98-1.20	
History of diabetes mellitus										
Yes	709	163	372	44%	158	337	47%	1.05	0.84-1.31	0.94

<i>(Continued)</i>										
No	7316	1456	3927	37%	1250	3389	37%	1.06	0.98-1.14	
Missing / not reported	5908	1024	3335	31%	942	2573	37%	1.06	0.97-1.16	
Geographical region										
Northern America	3569	490	2004	24%	470	1565	30%	1.11	0.98-1.27	0.90
Northern, Western & Southern Europe	7440	1529	4030	38%	1322	3410	39%	1.05	0.98-1.13	
Eastern Europe	1955	514	1030	50%	469	925	51%	1.03	0.91-1.17	
Australia & New Zealand	342	40	216	19%	28	126	22%	1.08	0.66-1.75	
Other	226	48	123	39%	46	103	45%	0.95	0.63-1.43	
Missing / not reported	401	22	231	10%	15	170	9%	1.47	0.75-2.89	
Tumour stage										
Metastatic / advanced	8113	1918	4482	43%	1698	3631	47%	1.05	0.98-1.12	0.86
Not metastatic / not advanced	4039	420	2116	20%	408	1923	21%	1.06	0.93-1.22	
Missing / not reported	1781	305	1036	29%	244	745	33%	1.04	0.87-1.23	
Planned Hb ceiling										
Planned Hb ceiling (cat 1)										0.40
≤Hb 13.0 g/dL	3043	437	1624	27%	399	1419	28%	1.09	0.95-1.25	
Hb 13.0 - ≤15.0 g/dL	10193	2019	5631	36%	1782	4562	39%	1.04	0.97-1.11	
Hb >15.0 g/dL	494	159	259	61%	152	235	65%	1.21	0.97-1.51	
Other	203	28	120	23%	17	83	20%	1.13	0.61-2.07	
Planned Hb ceiling (cat 2)										0.60
≤Hb 13.0 g/dL	3043	437	1624	27%	399	1419	28%	1.09	0.95-1.25	

(Continued)

Hb 13.0 – ≤14.0 g/dL	6816	1142	3733	31%	1013	3083	33%	1.03	0.95-1.13	
Hb 14.0 – ≤15.0 g/dL	3377	877	1898	46%	769	1479	52%	1.05	0.95-1.15	
>Hb 15.0 g/dL	494	159	259	61%	152	235	65%	1.21	0.97-1.51	
Other	203	28	120	23%	17	83	20%	1.13	0.61-2.07	
Study level characteristics										
Treatment population										
Treatment population										
Chemotherapy	10441	1888	5676	33%	1667	4765	35%	1.04	0.97-1.11	0.11
Radiochemotherapy	737	204	368	55%	211	369	57%	0.91	0.75-1.10	
Radiotherapy	799	220	408	54%	196	391	50%	1.17	0.96-1.42	
Mixed	266	17	175	10%	7	91	8%	1.53	0.63-3.69	
None	1690	314	1007	31%	269	683	39%	1.22	1.04-1.44	
Treatment population										
Chemotherapy	10441	1888	5676	33%	1667	4765	35%	1.04	0.97-1.11	0.25
Radiotherapy / radiochemotherapy	1536	424	776	55%	407	760	54%	1.03	0.90-1.18	
Mixed	266	17	175	10%	7	91	8%	1.53	0.63-3.69	
None	1690	314	1007	31%	269	683	39%	1.22	1.04-1.44	
Iron supplementation										
Fixed iron supplementation	2589	468	1293	36%	467	1296	36%	1.00	0.87-1.13	0.48
Iron supplementation as needed	11120	2075	6232	33%	1782	4888	36%	1.07	1.00-1.14	
Other	224	100	109	92%	101	115	88%	1.17	0.89-1.55	

(Continued)

Planned ESA treatment duration										
Up to 8 weeks	415	55	256	21%	47	159	30%	1.09	0.74-1.62	0.74
9-16 weeks	4800	667	2738	24%	644	2062	31%	1.02	0.91-1.14	
> 17 weeks	3269	816	1701	48%	747	1568	48%	1.11	1.00-1.22	
Until end of chemo- or radiotherapy	5449	1105	2939	38%	912	2510	36%	1.05	0.96-1.14	
Planned weekly ESA dosage										
< 100 µg Darbepoetin or < 40000 IU Epoetin	4197	832	2297	36%	669	1900	35%	1.04	0.94-1.15	0.88
= 100 µg Darbepoetin or = 40000 IU Epoetin	3081	557	1545	36%	536	1536	35%	1.08	0.96-1.22	
> 100 µg Darbepoetin or > 40000 IU Epoetin	3845	876	2076	42%	808	1769	46%	1.08	0.98-1.19	
Other	2810	378	1716	22%	337	1094	31%	1.02	0.88-1.18	
Planned frequency of ESA application										
Three times per week or more frequent	6131	1067	3458	31%	840	2673	31%	1.07	0.98-1.18	0.07
Once per week	3948	911	1972	46%	886	1976	45%	1.06	0.97-1.17	
Every second week or less frequent	3036	347	1795	19%	286	1241	23%	1.20	1.02-1.40	
Other	818	318	409	78%	338	409	83%	0.90	0.77-1.05	
Placebo controlled trial										
Yes	7657	1578	4211	37%	1403	3446	41%	1.09	1.01-1.17	0.29
No	6276	1065	3423	31%	947	2853	33%	1.02	0.93-1.12	
Randomisation										
Adequate	3882	739	2047	36%	636	1835	35%	1.07	0.96-1.19	0.80
Unclear	10051	1904	5587	34%	1714	4464	38%	1.05	0.99-1.13	

(Continued)

Concealment of allocation										
Adequate	10595	2176	5839	37%	1901	4756	40%	1.07	1.00-1.14	0.49
Unclear	3338	467	1795	26%	449	1543	29%	1.02	0.89-1.16	
Endpoint survival										
Primary endpoint	3116	732	1547	47%	715	1569	46%	1.02	0.92-1.13	0.39
Secondary endpoint	4313	1164	2282	51%	985	2031	48%	1.04	0.96-1.14	
Safety /adverse events	6504	747	3805	20%	650	2699	24%	1.13	1.01-1.25	
Designed for long-term follow-up										
Yes	8974	2213	4619	48%	1972	4355	45%	1.06	1.00-1.13	0.64
No	4959	430	3015	14%	378	1944	19%	1.03	0.89-1.18	
Year of last patient randomized										
1990-1994	1447	100	890	11%	70	557	13%	0.96	0.70-1.31	0.13
1995-1999	1725	312	1001	31%	224	724	31%	0.97	0.81-1.16	
2000-2004	7620	1453	4105	35%	1296	3515	37%	1.13	1.04-1.21	
2005-2006	3141	778	1638	47%	760	1503	51%	0.99	0.89-1.09	
Source of data										
Manufacturer	12229	2434	6789	36%	2151	5440	40%	1.06	1.00-1.13	0.57
Clinical study group	1704	209	845	25%	199	859	23%	1.00	0.83-1.22	
*P value for likelihood-ratio test (test for interaction), patients with missing data are excluded from this test, analysis based on one-stage Cox fixed-effects model stratified by study										
ESA= erythropoiesis-stimulating agents										

Appendix 9. Assessment of interaction for overall survival in chemotherapy trials

Overall survival chemotherapy trials											
Subgroups	Patients			ESA arm			Control arm			ESA versus control	
		events	sample %	events	sample %	events	sample %	HR	95% CI	P value*	
Patient level characteristics											
Hb at baseline											
Hb at baseline (continuous)										0.49	
Hb at baseline (cat. 1)											
Hb ≤ 8 g/dL	569	121	321 38%	100	248	40%	1.08	0.83-1.41	0.88		
Hb 8-≤10 g/dL	2888	533	1606 33%	504	1282	39%	0.99	0.88-1.12			
Hb 10-≤12 g/dL	3748	706	2121 33%	572	1627	35%	1.06	0.95-1.18			
Hb 12-≤14 g/dL	2185	401	1108 36%	377	1077	35%	1.08	0.94-1.24			
Hb >14 g/dL	555	83	286 29%	70	269	26%	1.13	0.82-1.55			
Unknown	496	44	234 19%	44	262	17%	1.08	0.71-1.65			
Hb at baseline (cat. 2)											
Hb ≤ 8 g/dL	569	121	321 38%	100	248	40%	1.08	0.83-1.42	0.98		
Hb 8-≤9 g/dL	949	182	549 33%	175	400	44%	1.00	0.81-1.23			
Hb 9-≤10 g/dL	1939	351	1057 33%	329	882	37%	0.99	0.85-1.16			
Hb 10-≤11 g/dL	2074	375	1179 32%	290	895	32%	1.08	0.93-1.27			
Hb 11-≤12 g/dL	1674	331	942 35%	282	732	39%	1.03	0.88-1.20			
Hb 12-≤13 g/dL	1359	287	679 42%	275	680	40%	1.09	0.92-1.28			

(Continued)

Hb 13-≤14 g/dL	826	114	429	27%	102	397	26%	1.09	0.83-1.43	
Hb >14 g/dL	555	83	286	29%	70	269	26%	1.13	0.82-1.55	
Unknown	496	44	234	19%	44	262	17%	1.09	0.71-1.66	
Malignancy type										
Tumour (cat. 1)										
Haematological malignancies	1832	335	1034	32%	264	798	33%	1.13	0.96-1.33	0.33
Solid tumours	7967	1410	4311	33%	1271	3656	35%	1.03	0.96-1.12	
Other	600	139	314	44%	129	286	45%	0.90	0.71-1.15	
Missing / unknown	42	4	17	24%	3	25	12%	2.12	0.47-9.54	
Tumour (cat. 2)										
Haematological malignancies	1832	335	1034	32%	264	798	33%	1.12	0.95-1.32	0.33
Breast cancer	4038	536	2076	26%	454	1962	23%	1.15	1.01-1.30	
Head and neck cancer	26	3	12	25%	3	14	21%	0.49	0.10-2.43	
Lung cancer	2237	705	1172	60%	695	1065	65%	0.96	0.87-1.07	
Gastrointestinal cancer	429	84	267	31%	65	162	40%	0.89	0.64-1.24	
Gynaecological cancer	1077	64	681	9%	39	396	10%	1.16	0.77-1.73	
Genitourinary cancer	160	18	103	17%	15	57	26%	1.05	0.52-2.10	
Other	600	139	314	44%	129	286	45%	0.91	0.72-1.16	
Missing / unknown	42	4	17	24%	3	25	12%	2.09	0.47-9.40	
Sex										
Male	3125	806	1720	47%	750	1405	53%	0.96	0.87-1.06	0.04

<i>(Continued)</i>										
Female	7316	1082	3956	27%	917	3360	27%	1.10	1.01-1.21	
Age										
Age continuous										0.41
Age categorical										
< 18 years	123	0	55	0%	1	68	1%	Not estimable	Not estimable	0.40
≥18-35 years	312	32	171	19%	23	141	16%	0.95	0.55-1.62	
≥35-45 years	1135	150	620	24%	120	515	23%	0.97	0.76-1.23	
≥45-55 years	2425	392	1311	30%	323	1114	29%	1.15	0.99-1.33	
≥55-65 years	3233	594	1724	34%	573	1509	38%	0.98	0.87-1.10	
≥65-75 years	2444	539	1359	40%	489	1085	45%	1.03	0.91-1.17	
≥75 years	758	181	430	42%	137	328	42%	1.17	0.94-1.47	
Missing	11	0	6	0%	1	5	20%	Not estimable	Not estimable	
Hct levels at baseline										
Hct continuous										0.25
Hct categorical										
≤ 23.5%	275	51	144	35%	42	131	32%	1.36	0.90-2.05	0.24
23.5 ≤ 29.4%	2033	340	1135	30%	338	898	38%	0.93	0.80-1.08	
29.4 ≤ 35.3%	3281	689	1882	37%	531	1399	38%	1.05	0.94-1.18	
35.3 ≤ 41.2%	1801	400	931	43%	386	870	44%	1.05	0.91-1.20	
> 41.2%	459	84	249	34%	66	210	31%	1.30	0.94-1.79	

(Continued)

Missing / unknown	2592	324	1335	24%	304	1257	24%	1.07	0.91-1.25		
Serum Epo at baseline											
Serum Epo continuous											1.00
Serum Epo categorical											
< 25 mU/ml	1032	235	608	39%	225	424	53%	0.91	0.76-1.09	0.49	
25-100 mU/ml	2083	434	1162	37%	415	921	45%	0.94	0.82-1.08		
100-200 mU/ml	518	143	314	46%	92	204	45%	1.17	0.90-1.52		
200-500 mU/ml	227	47	134	35%	39	93	42%	1.13	0.74-1.73		
> 500 mU/ml	99	14	57	25%	15	42	36%	0.76	0.36-1.58		
Unknown	6482	1015	3401	30%	881	3081	29%	1.10	1.01-1.21		
Performance score											
ECOG categorical											
ECOG 0	3025	320	1582	20%	309	1443	21%	1.06	0.90-1.24	0.34	
ECOG 1	3784	820	2105	39%	671	1679	40%	1.07	0.96-1.18		
ECOG 2	1140	337	623	54%	309	517	60%	0.96	0.82-1.12		
ECOG 3	105	37	57	65%	29	48	60%	0.94	0.57-1.53		
ECOG 4	3	2	2	100%	0	1	0%	Not es- timable	Not estimable		
ECOG missing	2384	372	1307	28%	349	1077	32%	1.03	0.89-1.19		
ECOG dichotomous											
ECOG 0, 1, 2	7949	1477	4310	34%	1289	3639	35%	1.04	0.97-1.13	0.92	

(Continued)

ECOG 3, 4	108	39	59	66%	29	49	59%	1.02	0.63-1.65	
ECOG missing	2384	372	1307	28%	349	1077	32%	1.02	0.88-1.19	
Body mass index										
≤ 19 kg/m ²	607	107	292	37%	116	315	37%	0.86	0.66-1.12	0.52
19-≤ 25 kg/m ²	4283	796	2318	34%	685	1965	35%	1.03	0.93-1.14	
25-≤ 30 kg/m ²	2698	477	1468	32%	393	1230	32%	1.07	0.94-1.23	
> 30 kg/m ²	1294	177	686	26%	161	608	26%	1.00	0.81-1.24	
Missing	1559	331	912	36%	312	647	48%	1.11	0.95-1.30	
History of thromboembolic events										
Yes	375	96	207	46%	72	168	43%	1.10	0.81-1.50	0.68
No	6292	1136	3469	33%	972	2823	34%	1.03	0.94-1.12	
Missing / not reported	3774	656	2000	33%	623	1774	35%	1.04	0.93-1.17	
History of cardiovascular events										
Yes	2319	481	1295	37%	385	1024	38%	1.06	0.92-1.21	0.78
No	5050	802	2721	29%	701	2329	30%	1.03	0.93-1.14	
Missing / not reported	3072	605	1660	36%	581	1412	41%	1.03	0.92-1.15	
History of hypertension										
Yes	1396	318	798	40%	255	598	43%	1.03	0.87-1.21	0.91
No	5271	914	2878	32%	789	2393	33%	1.04	0.94-1.14	
Missing / not reported	3774	656	2000	33%	623	1774	35%	1.04	0.93-1.17	
History of diabetes mellitus										

(Continued)

Yes	430	85	219	39%	92	211	44%	0.97	0.72-1.31	0.62
No	5149	937	2786	34%	751	2363	32%	1.05	0.96-1.16	
Missing / not reported	4862	866	2671	32%	824	2191	38%	1.03	0.94-1.14	
Geographical region										
Northern America	2083	306	1088	28%	315	995	32%	1.05	0.90-1.23	0.93
Northern, Western & Southern Europe	6082	1131	3342	34%	929	2740	34%	1.05	0.96-1.15	
Eastern Europe	1413	363	734	49%	346	679	51%	0.99	0.85-1.14	
Australia & New Zealand	286	27	184	15%	21	102	21%	1.01	0.57-1.80	
Other	189	45	106	42%	44	83	53%	0.92	0.61-1.40	
Missing / not reported	388	16	222	7%	12	166	7%	1.54	0.71-3.32	
Tumour stage										
Metastatic / advanced	6054	1379	3325	41%	1221	2729	45%	1.03	0.96-1.12	0.60
Not metastatic / not advanced	2902	248	1491	17%	234	1411	17%	1.09	0.91-1.31	
Missing / not reported	1485	261	860	30%	212	625	34%	0.93	0.77-1.12	
Planned Hb ceiling										
Planned Hb ceiling (cat. 1)										
≤Hb 13.0 g/dL	1631	105	841	12%	97	790	12%	1.06	0.80-1.40	0.57
Hb 13.0 - ≤15.0 g/dL	8451	1664	4630	36%	1464	3821	38%	1.03	0.96-1.10	
Hb >15.0 g/dL	280	104	150	69%	101	130	78%	1.20	0.91-1.58	
Other	79	15	55	27%	5	24	21%	1.45	0.53-4.00	
Planned Hb ceiling (cat. 2)										

(Continued)

≤Hb 13.0 g/dL	1631	105	841	12%	97	790	12%	1.06	0.80-1.40	0.77
Hb 13.0 ≤14.0 g/dL	5930	969	3200	30%	855	2730	31%	1.03	0.94-1.13	
Hb 14.0 ≤15.0 g/dL	2521	695	1430	49%	609	1091	56%	1.02	0.92-1.14	
>Hb 15.0 g/dL	280	104	150	69%	101	130	78%	1.20	0.91-1.58	
Other	79	15	55	27%	5	24	21%	1.45	0.53-4.00	
Study level characteristics										
Iron supplementation										
Fixed iron supplementation	1904	248	947	26%	233	957	24%	1.12	0.94-1.35	0.41
Iron supplementation as needed	8313	1540	4620	33%	1333	3693	36%	1.02	0.94-1.09	
Other	224	100	109	92%	101	115	88%	1.17	0.89-1.55	
Planned ESA treatment duration										
Up to 8 weeks	143	5	114	4%	3	29	10%	0.69	0.13-3.56	0.72
9-16 weeks	3823	591	2075	28%	590	1748	34%	0.99	0.88-1.11	
> 17 weeks	2280	566	1184	48%	531	1096	48%	1.06	0.94-1.19	
Until end of chemo- or radiotherapy	4195	726	2303	32%	543	1892	29%	1.07	0.96-1.20	
Planned weekly ESA dosage										
< 100 µg Darbeпоetin or < 40000 IU Epoetin	3733	794	2023	39%	645	1710	38%	1.03	0.92-1.14	0.37
= 100 µg Darbeпоetin or = 40000 IU Epoetin	2200	292	1101	27%	264	1099	24%	1.19	1.00-1.40	
> 100 µg Darbeпоetin or > 40000 IU Epoetin	1998	498	987	50%	496	1011	49%	0.99	0.88-1.12	
Other	2510	304	1565	19%	262	945	28%	1.01	0.86-1.20	
Planned frequency of ESA application										

(Continued)

Three times per week or more frequent	5016	846	2853	30%	652	2163	30%	1.04	0.94-1.16	0.16
Once per week	3067	646	1528	42%	614	1539	40%	1.10	0.99-1.23	
Every second week or less frequent	1540	78	886	9%	63	654	10%	1.19	0.85-1.67	
Other	818	318	409	78%	338	409	83%	0.90	0.77-1.05	
Placebo controlled trial										
Yes	5473	1118	2996	37%	1010	2477	41%	1.03	0.95-1.12	0.77
No	4968	770	2680	29%	657	2288	29%	1.05	0.95-1.17	
Randomisation										
Adequate	3258	649	1693	38%	553	1565	35%	1.04	0.93-1.17	0.90
Unclear	7183	1239	3983	31%	1114	3200	35%	1.04	0.96-1.12	
Concealment of allocation										
Adequate	8252	1679	4501	37%	1476	3751	39%	1.02	0.95-1.10	0.26
Unclear	2189	209	1175	18%	191	1014	19%	1.16	0.95-1.41	
Endpoint survival										
Primary endpoint	2731	586	1352	43%	556	1379	40%	1.08	0.96-1.22	0.58
Secondary endpoint	3222	886	1730	51%	738	1492	49%	1.00	0.91-1.11	
Safety /adverse events	4488	416	2594	16%	373	1894	20%	1.05	0.91-1.21	
Designed for long-term follow-up										
Yes	6509	1539	3355	46%	1350	3154	43%	1.05	0.98-1.13	0.47
No	3932	349	2321	15%	317	1611	20%	0.99	0.84-1.15	
Year of last patient randomized										

(Continued)

1990-1994	1057	70	650	11%	51	407	13%	0.88	0.61-1.27	0.18
1995-1999	1725	312	1001	31%	224	724	31%	0.97	0.81-1.16	
2000-2004	6112	1135	3263	35%	1012	2849	36%	1.10	1.01-1.20	
2005-2006	1547	371	762	49%	380	785	48%	0.94	0.82-1.09	
Source of data										
Manufacturer	8851	1701	4889	35%	1485	3962	37%	1.05	0.97-1.12	0.54
Clinical study group	1590	187	787	24%	182	803	23%	0.98	0.80-1.20	
*P value for likelihood-ratio test (test for interaction), patients with missing data are excluded from this test, analysis based on one-stage Cox fixed-effects model stratified by study										
ESA= erythropoiesis-stimulating agents										

WHAT'S NEW

Date	Event	Description
29 September 2010	Amended	funding number added

CONTRIBUTIONS OF AUTHORS

JULIA BOHLIUS: protocol development, protocol revision, literature searches and study selection, data extraction, data management, statistical analyses, first draft of review, revision of review, project management

KURT SCHMIDLIN: data management, statistical analyses, revision of review

CORINNE BRILLANT: protocol revision, data management, revision of review

GUIDO SCHWARZER: protocol development, protocol revision, statistical analyses, revision of review

SVEN TRELLE: protocol development, protocol revision, statistical analyses, revision of review

JEROME SEIDENFELD: protocol revision, extensive revision of review

MARCEL ZWAHLEN: protocol revision, statistical analyses

MICHAEL CLARKE: protocol revision, revision of review

OLAF WEINGART: protocol revision, literature searches and study selection, revision of review

SABINE KLUGE: data extraction, revision of review

MARYANN NAPOLI: revision of protocol and review, drafting plain language summary

MARGRET PIPER: protocol revision, extensive revision of review

DIRK RADES: protocol revision, revision of review

DAVID P. STEENSMA: protocol revision, revision of review

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ISABELLE RAY-COQUARD: contributed the data from clinical trial, revision of review

VOLKER MOEBUS: contributed the data from clinical trial, revision of review

GILLIAN THOMAS: contributed the data from clinical trial, revision of review

MICHAEL UNTCH: contributed the data from clinical trial, revision of review

MARTIN SCHUMACHER: protocol revision, revision of review, support for statistical analyses

MATTHIAS EGGER: protocol development, protocol revision, revision of review, supervision of study

ANDREAS ENGERT: protocol revision, revision of review, supervision of study

DECLARATIONS OF INTEREST

Julia Bohlius received honoraria and travel grants from Amgen. Andreas Engert received research funding and honoraria from Amgen, Roche and Johnson & Johnson. Gillian Thomas received research funding for the GOG-191 study by Johnson & Johnson. Benjamin Djulbegovic received research funding from OrthoBiotech and consulted for Amgen. Volker Moebus received research funding and honoraria from Amgen, Bristol-Myers Squibb, GlaxoSmithKline, Johnson & Johnson, Novartis, Pfizer, and Roche. Michael Untch received research funding for the PREPARE study from Amgen and Bristol-Myers Squibb. Margaret Piper is employed by the Blue Cross and Blue Shield Association, the trade organization for the independent US Blue Cross Blue Shield health insurance plans, but is not involved in the

determination of coverage and reimbursement policy for individual plans. All other members of the Steering Committee, the Statistical Analysis Team and Reviewers declared to have no conflict of interest.

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DIFFERENCES BETWEEN PROTOCOL AND REVIEW

Main difference is that the protocol covered several endpoints, i.e. survival, tumor progression, transfusion, QoL, thromboembolic events and other. In the current review only the endpoint survival is covered and the other endpoints will follow at later stages of the project. For literature based meta-analysis see [Bohlius 2004](#), [Bohlius 2005](#), [Bohlius 2006](#).

INDEX TERMS

Medical Subject Headings (MeSH)

*Erythrocyte Transfusion; Anemia [complications] [*mortality] [therapy]; Darbepoetin alfa; Disease-Free Survival; Epoetin Alfa; Erythropoietin [adverse effects] [analogs & derivatives]; Hematinics [*adverse effects]; Neoplasms [complications] [*mortality] [therapy]; Randomized Controlled Trials as Topic; Recombinant Proteins

MeSH check words

Adult; Child; Female; Humans; Male