

Supplement 2

Estimation of the expected mean survival time

First, we defined the expected MOST as 13.65 months. This is a well-established point confirmed either by official SEER data and a reliable retrospective analysis.¹ Then, we defined that median progression-free survival after 1st-line treatment, based on the data of 9 cohorts of 6 independent trials (Table S1), equals 7.5 months, and it well corresponds with general opinion that GBM relapses in 6-9 months after diagnosis. To define the most problematic final parameter MST since relapse, we studied the inner structure of the survival time, namely time-proportions between MOST, PFS and MST, on eight cohorts for which this information was available simultaneously (Table S2). Finally, we translated these data on the established MOST and MPFS and calculated the expected MST as 4.775 months (95%CI: 3.9 – 5.6) (Table S3).

Table S1. Median progression-free survival after standard 1-2 line treatment of GBM (WHO IV).

Study	Tumor, state	Treatment	MPFS m
Jungk (2016) ²	GBM, recurrent/progressive	2M (mainly no CTX)	6,10
Reithmeier (2010) ³	GBM, recurrent/progressive	3M (mainly TMZ)	8,72
Hamza (2014) ⁴	GBM, recurrent/progressive	3M	8,10
Hamza (2014) ⁴	GBM, recurrent/progressive	3M	7,60
Strik (2008) ⁵	GBM, recurrent/progressive	3M Stupp	7,53
Chinot (2014) ⁶	GBM, newly diagnosed	3M Stupp	6,20
Gilbert (2014) ⁷	GBM, newly diagnosed	3M Stupp	7,30
Gilbert (2013) ⁸	GBM, newly diagnosed	3M Stupp	7,50
Gilbert (2013) ⁸	GBM, newly diagnosed	3M ddTMZ	8,80
Average			7,56

Note: CTX: chemotherapy; TMZ: temozolomide; 3M – trimodal (SRG + XRT + CTX); 2M: bimodal (no CTX); Stupp: 3M SRG + (XRT 60 Gy X6w + TMZ 5/7d X 6w) + TMZ 5/28d X 6m; ddTMZ: dose-dense TMZ.

Table S2. Inner structure of survival time.

Study	Cohort	NOP	MOST	MPFS	MST	MST%	MST	PFS+	PFS+
Varkonyi (2003)	HGG	24	22,0	12,2	6,5	30%	18,7	85%	
Sahinbas (2007)	GBM (all)	76	20,0	8,5	7,6	38%	16,1	80%	
	GBM (mEHT)	18	14,8	8,0	6,4	43%	14,4	97%	
	GBM mEHT+TMZ)	58	20,9	9,3	7,6	36%	16,9	81%	
Jungk (2016)	GBM	34	15,7	6,1	8,7	56%	14,8	94%	
Hamza (2014)	GBM (early BEV)	112	20,8	8,1	11,0	53%	19,1	92%	
	GBM (late BEV)	133	25,9	7,6	9,9	38%	17,5	68%	
Strik (2008)	GBM	18	17,9	8,2	9,1	51%	17,3	97%	
Weighted average			21,5	8,2	9,1	43%	17,3	82%	
95%CI						36,9% –		75,3% –	
						48,8%		88,8%	

Note: NOP: number of patients; MOST: median overall survival time; MPFS: median progression-free survival; MST: median survival time since relapse; PFS: progression-free survival; HGG: high-grade gliomas; GBM: glioblastoma; mEHT: modulated electro-hyperthermia; TMZ: temozolomide; BEV: bevacizumab; CI: confidence interval.

Table S3. Calculation of estimated mean survival time since relapse.

	95% CI		
	Mean	Lower	Upper
		limit	limit
MOST, months	13,65		
MPFS, months	7,5		
MPFS+MST (%)	82,0%	75,3%	88,8%
MPFS+MST, months	11,2	10,3	12,1
mST (1 st estimation), months	3,7	2,8	4,6
MST (%)	42,9%	36,9%	48,8%

	95% CI			
	Mean	Lower	Upper	SE
		limit	limit	
MST (2 nd estimation), months	5,9	5,0	6,7	
mST (average), months	4,775	3,9	5,6	0,443

Note: MOST: median overall survival time; MPFS: median progression-free survival; MST: median survival time since relapse.

¹ Ray S, Bonafede MM, Mohile NA. Treatment Patterns, Survival, and Healthcare Costs of Patients with Malignant Gliomas in a Large US Commercially Insured Population. *Am Health Drug Benefits*. 2014 May; 7(3): 140–149.

² Jungk C, Chatziaslanidou D, Ahmadi R, Capper D, Bermejo JL, Exner J, von Deimling A, Herold-Mende C, Unterberg A. Chemotherapy with BCNU in recurrent glioma: Analysis of clinical outcome and side effects in chemotherapy-naïve patients. *BMC Cancer*. 2016 Feb 10;16:81. doi: 10.1186/s12885-016-2131-6.

³ Reithmeier T, Graf E, Piroth T, Trippel M, Pinsker MO, Nikkhah G. BCNU for recurrent glioblastoma multiforme: efficacy, toxicity and prognostic factors. *BMC Cancer*. 2010 Feb 2;10:30. doi: 10.1186/1471-2407-10-30.

⁴ Hamza MA, Mandel JJ, Conrad CA, Gilbert MR, Yung WK, Puduvalli VK, DeGroot JF. Survival outcome of early versus delayed bevacizumab treatment in patients with recurrent glioblastoma. *J Neurooncol*. 2014 Aug;119(1):135–40. doi: 10.1007/s11060-014-1460-z.

⁵ Strik HM, Buhk JH, Wrede A, Hoffmann AL, Bock HC, Christmann M, Kaina B. Rechallenge with temozolamide with different scheduling is effective in recurrent malignant gliomas. *Mol Med Rep*. 2008 Nov-Dec;1(6):863–7. doi: 10.3892/mmr_00000042.

⁶ Chinot OL, Wick W, Mason W, Henriksson R, Saran F, Nishikawa R, Carpentier AF, Hoang-Xuan K, Kavan P, Cernea D, Brandes AA, Hilton M, Abrey L, Cloughesy T. Bevacizumab plus radiotherapy-temozolamide for newly diagnosed glioblastoma. *N Engl J Med*. 2014 Feb 20;370(8):709–22. doi: 10.1056/NEJMoa1308345.

⁷ Gilbert MR, Dignam JJ, Armstrong TS, Wefel JS, Blumenthal DT, Vogelbaum MA, Colman H, Chakravarti A, Pugh S, Won M, Jeraj R, Brown PD, Jaeckle KA, Schiff D, Stieber VW, Brachman DG, Werner-Wasik M, Tremont-Lukats IW, Sulman EP, Aldape KD, Curran WJ Jr, Mehta MP. A randomized trial of bevacizumab for newly diagnosed glioblastoma. *N Engl J Med*. 2014 Feb 20;370(8):699–708. doi: 10.1056/NEJMoa1308573.

⁸ Gilbert MR, Wang M, Aldape KD, Stupp R, Hegi ME, Jaeckle KA, Armstrong TS, Wefel JS, Won M, Blumenthal DT, Mahajan A, Schultz CJ, Erridge S, Baumert B, Hopkins KI, Tzuk-Shina T, Brown PD, Chakravarti A, Curran WJ Jr, Mehta MP. Dose-dense temozolamide for newly diagnosed glioblastoma: a randomized phase III clinical trial. *J Clin Oncol*. 2013 Nov 10; 31(32):4085–91.